University of Alberta

A Study of Speech-Language Pathology Services for School-Age Children within a Health Region in Alberta

by

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Abstract

Provision of speech-language services to school-age children residing within a health region in Alberta was investigated as an example of an organizational system responsible for providing these services in Canada. Institutional ethnography was the methodology employed in this study. During stage 1, on-site practice observations and interviews were conducted with 14 front-line speech-language pathologists selected to represent urban and rural sites, schools only and schools/preschool practice, and, team and sole practice. A detailed description of their work was developed, including an examination of their perceived ideal and currently practiced roles. Two perspectives on the ideal role emerged: a specific and task-oriented perspective and an overarching and philosophical perspective. Discord between two themes of doing "what was best" for clients and role ambiguity was identified. Participants' currently practiced role was both client- and service-focused. Discord was evident in practice as participants struggled to manage their caseloads within the service time available. Significant role conflict existed because current practice did not reflect the perceived ideal and this conflict jeopardized work satisfaction and ethical practice. At the second stage, health region managers, teachers and education administrators, a regional consulting team, and government employees were interviewed and policy documents were reviewed. The influence of the organizational and governmental context on front-line speech-language pathology practice was explicated. Participants were found to practice in a hybrid work world formed by the health and education contexts. Participant attempts to negotiate this context required significant time and energy, interfered with their work satisfaction, and failed to guarantee any particular level of service.

Implications of the findings included (a) speech-language pathologists require research and administrative guidance to reconcile global service delivery concerns with considerations focused on individual client needs, (b) caseload management and supervisory duties undertaken by speech-language pathologists must be carefully reconsidered and monitored, and (c) conflicts between health and education contexts must be reconciled to remove barriers to the delivery of speech-language services to children. A plan is provided that identifies specific actions that can be taken by key constituents: speech-language pathologists, administrators, training institutions, professional colleges and associations, policy makers, and the research community to re-vision and restructure speech-language services for Canadian schoolchildren.

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Doctoral study is sometimes perceived as a very solitary pursuit. I would argue that similarly to how it has been said that "it takes a village to raise a child", it takes the assistance and support of many individuals to enable one to "raise" a doctoral study. I am pleased to take this opportunity to extend my sincere gratitude to the following:

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CHAPTER ONE: INTRODUCTION

It is July 2002, I am sitting at a table in the middle of an enormous hotel ballroom in Nashville, Tennessee. Along with nearly 600 other school speech-language pathologists attending this conference, I am waiting with anticipation for the keynote presentation of a new way of managing our workload. While I wait I think about my experiences as a Canadian school speech-language pathologist – about the frustrations involved in rationing services to the point where I wonder if any beneficial effect can possibly result and I think about the panic and distress I see in parents' faces when I tell them that despite their children's obvious needs I must add them to my ever-increasing waiting list. In an attempt to brush these negative thoughts aside, I think of the joys of my professional life – about the mothers who have cried upon hearing their children's new speaking abilities for the first time and about the students whose pride in their new improved language skills has given them the confidence to participate fully in classroom activities and school presentations. I wonder to what extent the members of this largely American audience would relate to these thoughts.

Finally, there is a speaker at the podium. She begins by stating that the American Speech-Language-Hearing Association's most recent recommendation on caseload size was that caseloads should not exceed 50 students and that this recommendation had not been followed. To demonstrate her point, she asks those members of the audience who have more than 50 students on their caseloads to stand up. Nearly all of us do. The speaker then explains that she will call out numbers and that audience members are to remain standing only if they have more students than that on their caseloads. She calls out 60 and many members of the audience sit down. She calls out 70 and 80. The overwhelming majority of audience members are now seated. I am still standing and I am aware of a murmur from the audience members in my immediate area. The tone is not one of admiration.

The speaker wonders aloud if there are actually speech-language pathologists with caseloads of over 100 students in the audience. I look around and notice about five people standing with me. I wonder if they are from Canada too. The speaker exclaims that it is impossible to be effective with that many students. As I sit down I wonder about the truth of this statement and I think about my caseload of 170 students and the fact that I know

Canadian school speech-language pathologists with caseloads even higher than mine. I knew then that the questions I had long harboured about the way speech-language services are provided to Canadian schoolchildren had become too critical to ignore.

Purpose of the Research

The purpose of my study was to investigate the provision of speech-language services to school-age children residing within a health region in Alberta as an example of an organizational system responsible for providing speech-language services to school-age children in Canada. The first objective was to develop a detailed description of the work of front-line speech-language pathologists including an examination of their perceived ideal role and their currently practiced role. The second objective was to explicate the influence of organizational and governmental policies on front-line practice. The ultimate aim of the research was to identify and clarify issues related to the provision of speech-language services to school-age children that would not only provide practice and policy guidance locally but would also be relevant to clinicians, administrators, professional training institutions, professional colleges and associations, policy makers, and the research community provincially and nationally.

Significance of the Study

Research conducted over the past 30 years has suggested that at least 10% of school-age children exhibit some kind of communication disorder (Beitchman, Nair, Clegg, & Patel, 1986; Shriberg, Tomblin, & McSweeny, 1999; Tomblin, Records, Buckwalter, Xuyang, Smith, & O'Brien, 1997). The 10% figure can be used to estimate the presence in Canadian schools of approximately 600,000 children with communication disorders (Statistics Canada, 2006). The number of children with identified communication disorders may increase as we come to recognize that over 60% of students with behavior disorders have significant language problems (Cantwell & Baker, 1991) and 75-80% of students with learning disabilities have related language problems (Casby, 1989).

Because their disorders are often invisible, the needs of children with communication disorders are typically not well understood by either the general public or those charged with making policy decisions (Soutar-Hynes, 1996), yet the consequences of their difficulties are often profound. Children with communication disorders may have difficulty learning in school and in developing social relationships with peers and family (Warr-Leeper, 1998). The language-learning link is disrupted for these children. As noted by Vail (1996), "language is a key to information, emotion, past experience, current happenings, and future goals" (p. 2). Children with weak receptive language skills will struggle to understand explanations, directions, narratives, and abstract reasoning. Children with weak expressive language skills may have difficulty remembering specific labels for objects and concepts and may therefore have difficulty making learning connections. Social-emotional development suffers when language does not develop appropriately. Children who lack the language to take turns have difficulty making friends. Weak language skills can also prevent sharing feelings, trading news, and making plans. Many oral language difficulties have the potential to negatively influence children's acquisition of literacy skills (Catts & Kamhi, 1999). Spoken language and written language rely on a common vocabulary and the explicit phonological awareness required to become a proficient reader is based on the perceptual and biological bases of spoken language. Children who have difficulty pronouncing speech sounds may also have difficulty learning to represent those sounds in print. While the learning and social difficulties related to communication disorders may first become evident during the preschool and elementary school years, this challenges do not disappear without intervention. Literacy difficulties linked to communication disorders have been identified in up to 75% of individuals remanded to adult correctional facilities (Henri & Hallowell, 2001).

The consequences of communication disorders are likely to increase as our world continues to move into and through the "Information Age" (Toffler, 1980). Henri and Hallowell (2001) noted that individuals are being asked to manage greater amounts of complex language-based information and that "those who have difficulty communicating risk becoming marginal participants in our society" (p. 338). Children are not immune from these forces as affirmed by those who have commented on the increasing complexity of the school curriculum.

Speech-language services for school-age children have been found to result in many positive outcomes including significant gains in reading skills (Hoffman & Norris, 1994), meaningful improvements in adaptive classroom behavior (Schery & O'Connor, 1992), substantial reductions in the drop-out rate for secondary school students (Larson & McKinley, 1995), and lasting benefits for at-risk children representing significant societal savings (Schweinhart, Berreuta-Clement, Barnett, Epstein, & Weikart, 1985). Despite the large number of children with significant communication disorders and the documented benefits of speech-language services, there is a dearth of information about the provision of services to Canadian schoolchildren. A 1985 national report called for this information gap to be filled (Minister of National Health and Welfare, 1985), but studies sponsored by professional associations and provincial governments have focused mainly on demographic profiles of personnel resources (CASLPA, 1990) and on categorizing services available in specific provinces (Alexander, 1986; Government of Nova Scotia, 1997; Soutar-Hynes, 1996). These reports, while useful in specific contexts, have not provided either detailed information about the practice of speech-language pathologists in Canadian schools or insight into the organization and government context in which services are provided.

Currently, speech-language services in Canada often appear splintered due to a lack of clear government responsibilities, professional caseloads so high that service may be either nonexistent or superficial, and the proliferation of privately-operated services for specific disability groups (e.g., autism) that are available only in urban areas. Job dissatisfaction and burnout have become issues for Canadian SLPs serving school-age children with a suggestion that these issues stem from practitioners being unable to fulfill their desired work role (Kaegi, Svitich, Chambers, Bakker, & Schneider, 2002; Potter & Lagacé, 1995). Yet there have been no studies fully documenting how front-line Canadian SLPs perceive and actualize their roles in serving school-age children. Burnett (2003) examined the perspectives that rehabilitation therapists, including SLPs, held of their working lives in Ontario but her work focused exclusively on the challenges encountered in serving children with physical disabilities educated in inclusive settings. While this study provided useful information about participants' experiences serving that population, this is but one small area of practice for most Canadian SLPs serving school-age children. There has been some discussion of a preferred "education model" for delivery of speech-language services to school-age children (Soutar-Hynes, 1996) but in many provinces, service provision has traditionally been, all or in part, a Health responsibility (Government of Nova Scotia, 1997) and this potential contradiction has not been investigated. Because of the educational impact of untreated communication disorders, ensuring sufficient speech-language services for school-age children should be of critical importance to Canadian educational systems. Because of the critical relationships between communication, education, quality of life, and wellbeing, speech-language services should be equally high importance to our health systems. If the efficiency, effectiveness, and availability of speech-language services to all school-age children are to be improved, a better understanding of front-line service provision and how the organizational and governmental context facilitates and/or constrains this service provision is critical. My study helps fill this gap.

Conceptual Framework

Through the literature review, a picture emerged of speech-language pathology as a young profession in Canada and of professional training provided within health faculties but with service delivery practices for school-age children influenced by American educational models. The need for speech-language services among school-age children was found to be significant in terms of the percentage of the school-age population likely requiring service (10%) but undefined according to the nature of the needs and the nature of services required and provided on the front line. The organizational and governmental systems responsible for administering speech-language services seemed to lack a clear conceptualization of front-line practice and their ability to fulfill identified commitments to providing service appropriate to the education context, to extending services, and to promoting outcomes research and evidence-based practice was therefore hindered.

Several areas of potential conflict in the work of front-line SLPs serving school-age children were identified in the literature and from anecdotal reports. Reports of job dissatisfaction and burnout among Canadian SLPs serving school-age children suggested that these issues were occurring because the SLPs could not practice in a way that was acceptable to them, meaning that there was a potential conflict between their perceived ideal work role and their currently practiced work role. A need for services for school-age children to be aligned in some way with the process of their education had been identified by numerous authors but what was meant by such "alignment" was not specifically defined and there were no descriptions of how alignment was negotiated in practice. These unanswered questions lay the foundation for further role confusion. The apparent inability of organizations and governments to conceptualize front-line SLP practice would directly influence SLP work roles, with the potential to either facilitate or exacerbate conflict, as the policies and practices of these organizations and governments formed the context that the SLPs worked in. The situation in many provinces, including Alberta, in which speech-language services to school-age children were provided, at least in part if not entirely, by health agencies, was anticipated to only compound the difficulties of providing speech-language services in an ill-defined "education model".

It was evident that detailed information on front-line practice and how organizational and governmental policies influenced speech-language service delivery was needed. Current practice issues such as those outlined in the literature review must be kept in mind as front-line practice is studied but general information on these issues cannot replace the need to understand how speech-language services are organized and provided. A critical need to understand if and how these apparent practice issues are addressed in front-line practice exists.

My study was directed towards addressing these research gaps. I used institutional ethnography to investigate the delivery of speech-language services to school-age children within a health region in the province of Alberta as an example of front-line service provision. Institutional ethnography is a qualitative approach for studying how practices, such as speech-language pathology, actually work (Smith, 1987). Concepts of work, conflict, textual media, and organizational decision-making from the field of institutional ethnography provided the theoretical starting point for describing front-line speech-language pathologists' practice within a health region in Alberta and explicating the influence of organizational and governmental policies on this practice.

Institutional ethnography provides a theory, or way of looking at work and work organizations. It is based on a social ontology, or a belief that everyday life is constituted by people whose activities are coordinated in specific ways, and seeks to make visible social relations, which are defined as the actual practices and activities through which people's lives are socially organized (Campbell & Gregor, 2002). In institutional ethnography, people are seen as actively constituting social relations, often unknowingly, as they coordinate their actions with professional standards or organizational processes (Smith, 1987). The method's broad consideration of "work" and focus on identifying how what people do and understand is shaped by organized processes (Campbell & Gregor, 2002) fit well with my study's purpose. In my study, the terms *work* and *practice* were used interchangeably as were *employment context* and *work context*. *Perceived ideal role* and *currently practiced role* were used to convey participants' ideal work and their currently practiced work respectively.

Institutional ethnographers begin by locating the problem for inquiry in a conflict arising from people's actual experience of the everyday world (Townsend, 1994). Smith (1987) has variously described the type of problem of interest as a "disjuncture", "bifurcation of consciousness", "line of fault", or "point of rupture" between subjective experiences in the everyday world and the world as it is otherwise known. Although these terms are not synonymous, each describes "those points of contradiction, tension, separation, or incongruence experienced between what is known of the everyday world and the way it is otherwise constructed, particularly by the official, often textual, practices of an institution" (Townsend, 1994, p. 25). Throughout my study, I chose to use the term *conflict* to represent this concept. The various areas of potential conflict in the work of front-line SLPs identified through the literature review therefore further contributed to making the institutional ethnographic approach appealing and appropriate.

Institutional ethnographers pay particular attention to how textual media are employed in contemporary work settings to process people and manage aspects of their lives. The "processing of people" is differentiated from organizational dealings with concrete products and includes the organizational strategies for training and managing employees as well as for managing work with clients. The textual media that this "processing of people" is enabled by, and occurs through, may include manuals, forms, and reports. Institutional ethnographic theory proposes that the processing of people through text is particularly true for occupations in the human services (Smith, 1999) making this theory particularly relevant to an investigation of speech-language pathology services. According to the theory, organizational processes exist in the human services to process people as potential clients of the organization and these processes are often put into place through (or mediated by) various organizational texts such as referral/application forms, assessment guidelines, and rules for eligibility.

Decision-making that arises out of this text mediation is viewed by institutional ethnographers as reflecting organizational interests or ruling interests (Smith, 1990). For example, Campbell and Gregor (2002) discussed how although the categories of an assessment form in a community health setting related to client interests in obtaining help, the text-mediated process of assessment subordinated client interests to those of the organization. They suggested that text-mediated processes in health service settings create versions of client stories that remove the individuals as the subjects of the stories and thereby create objectivity that is useful organizationally when tough decisions have to be made about access to limited services. Institutional ethnography views front-line practice as conflicted by subordination to organizational and governmental policies that are based on priorities and interests that are not those of either the workers or their clients. Institutional priorities and interests are seen as intervening in the relationships between workers and clients. The key to the extent of subordination and intervention is described as lying in how the policy texts are activated. Institutional ethnography's intense interest in the influence of organizational and governmental contexts on front-line work affirmed the utility of the approach for my study.

Discussion of Terms

Speech-language pathology has been defined as "the study of speech, language, and voice disorders for the purposes of diagnosis and treatment" (Nicolosi, Harryman, & Kresheck, 2004, p. 289). These same authors describe speech-language pathologists as individuals with degrees of certification in speech-language pathology who are qualified to diagnose speech, language, and voice disorders and to prescribe and implement therapeutic measures (Nicolosi et al., 2004, p. 289).

The Canadian Association of Speech-Language Pathologists and Audiologists (CASLPA) describes speech-language pathologists as autonomous professionals who have acquired an expertise in the area of human communication and its disorders. CASLPA indicates that speech-language pathologists may engage in screening, identification, evaluation, assessment, treatment, and management of communication and swallowing disorders; provision of counseling and education to clients, families, caregivers, and others related to communication and swallowing disorders; education and supervision of students and professionals; consultation with and referral to other professionals; research; and university instruction (CASLPA, 2004a). A master's level university degree in speech-language pathology is currently required for registration as a speech-language pathologist in Canada. Throughout this proposal I will use "speech-language services" to refer to the services provided either by or under the supervision of a speech-language pathologist. I will use the common acronym, SLP, to refer to speech-language pathologist.

In their work, SLPs address communication disorders. Communication disorders have been defined as impairments "in one or more of the processes of hearing, speech, or language that results in the inability to comprehend or express thoughts in oral, manual (e.g., sign language), or written form" (Moore-Brown & Montgomery, 2001, p. 409). Individuals with communication disorders may have difficulty understanding and using language. Those with speech disorders may have difficulty producing speech sounds accurately, may stutter, or may have problems with voice production such that their voices are persistently hoarse or absent. The norms of the community are used to judge whether or not individuals have communication disorders in contrast to communication differences; that is, communication disorders interfere with the ability to communicate effectively in the local community.

When discussing children's speech and language, a distinction is often made between 'delay' and 'disorder'. According to Martin and Miller (2003), delay is the term most often used when the speech and language characteristics are similar to that expected for a younger child while disorder is used when the presentation is quantitatively and qualitatively different. The *ICD-10 Classification of Mental and Behavioral Disorders* (World Health Organization, 1992), however, used the term specific developmental disorders of speech and language to refer to both impairments and delays in children's development of speech and language functions. Throughout this proposal I will use the term "communication disorder" to refer to disorders and delays in children's development of speech and language that result in significant difficulties communicating with others in their communities and in their learning environments.

Speech-language interventions seek to "affect change in communicative behavior to maximize an individual's potential to communicate effectively" (Roth & Paul, 2002, p. 159). Olswang and Bain (1991) noted that intervention can be targeted towards eliminating the underlying cause of the disorder, teaching the individual compensatory strategies to improve functional communication, or modifying the disorder by teaching specific speech, language, or pragmatic behaviors that enable an individual to become a more mature communicator. Speech-language pathologists plan interventions according to the nature of the disorder, the age and therapy history of the individual, the setting, and the client's learning styles and preferences (Roth & Paul, 2002).

Caseload is a term used to refer to the individuals (or number of individuals) receiving services from a SLP (Moore-Brown & Montgomery, 2001). For example, SLPs may refer to having children with autism and cerebral palsy on their caseloads or refer to having a caseload of 70, meaning that 70 individuals are receiving services.

CHAPTER TWO: REVIEW OF RELATED LITERATURE

Speech-language services can be considered according to the providers of the service, their role, and the context in which they work. The ensuing review examines the literature related to each of these three areas. In keeping with the purpose of the study, the focus will be on services for the school-age population.

The Profession of Speech-Language Pathology in Canada

Speech-language services are provided to Canadian schoolchildren by members of the speech-language pathology profession. In this section I will review the history of the profession in Canada as well as current data on SLPs and their contemporary workforce issues.

History of the Profession

Little has been written about the evolution of speech-language pathology as a profession in Canada. The earliest service in Canada appears to have been provided by the Montreal Children's Hospital in 1933 with the earliest school services beginning in Calgary in 1937 and in Winnipeg in 1938 (Martin, 2004). Virginia Martin (2003a) reported that Phyllis Middleton was hired as Winnipeg School Division's Teacher of Speech Correction and Lip Reading in 1938 and that by 1950, she supervised seven former teachers. One of these former teachers, Isabel Richard, was appointed the new head of the department in 1950 and in 1952 became the first speech therapist in Manitoba to hold an official degree in the profession after receiving her master's degree from Kent State University in Ohio (Martin, 2003a). The first two Canadian university programs were also created in the 1950s – at the Université de Montréal in 1956 and at the University of Toronto in 1958 (Doehring & Coderre, 1989, p. 37).

The Canadian Association of Speech-Language Pathologists and Audiologists (CASLPA) was launched in 1964 under the name of the Canadian Speech and Hearing Association (CASLPA, 1999a). In the first CSHA directory published in June 1965, various titles were used including speech therapist, speech pathologist, speech and hearing clinician, speech correctionist, speech and hearing therapist, and speech clinician (Martin, 1996a). A publication commemorating CASLPA's 35th anniversary noted that in 1964, "The professions were just starting to bud in Canada, and were painstakingly beginning to define and validate their place within the realm of medical science, health, and education" (CASLPA, 1999a). Martin (2003b) reported that "In the Hall Report (The Royal Commission on Health Services, Vol. 2, Queen's Printer, Ottawa, 1965) under the Heading of 'Speech and Audiological Therapists' it states: 'Statistics on speech therapists are lacking….It is estimated that there were between 100 and 125 qualified speech therapists in Canada in that year (1961). Most of them work in hospitals…It has been estimated that between 400 and 500 additional speech therapists are needed. At present existing professional training facilities graduate about 12 speech therapists per year; in addition another 10-20 foreign-trained speech therapists annually migrate to Canada. This annual gross increment is seriously inadequate in view of the shortage that exists in this country." (p. 5). Three more Canadian university programs were established in the 1960s – at McGill University in 1963 and at the University of Alberta and the University of British Columbia in 1969 (Doehring & Coderre, 1989).

The next national report, in 1973, in the second issue of *Human Communication*, represented the first published attempt to gather information about all SLPs and audiologists working in Canada. This directory, which did not manage to include all clinicians practicing at the time, listed 319 SLPs (Martin, 2004). Two more university programs were created in the 1970s – at the University of Western Ontario in 1970 and at Dalhousie University in 1976. Doehring and Coderre (1989) noted that all but one of the Canadian university programs in speech-language pathology were originally affiliated with faculties of medicine, three under rehabilitation medicine, one under otolaryngology, one under pediatrics, and one directly under the faculty of medicine. The remaining program was under a faculty of health professions. It is perhaps no surprise then that in the 1970s and early 1980s the majority of Canadian SLPs practiced in medical and clinical settings (CASLPA, 1999a).

Martin (1996a) has noted that in a 1971 *CHSA Directory*, professionals continued to refer to themselves by various titles including *speech and hearing clinician* and *speech and hearing therapist* with *speech pathologist* and *speech therapist* being the most popular titles. Finally, in 1984 CASLPA's membership endorsed *speech-language pathologist* as the uniform title (Martin, 2004). Martin (1996a) has suggested that the different titles over the years had to do with the early influences of British and American professional training on terminology and subsequent changes in professional scope of practice.

In the late 1990s two additional French language professional training programs were developed within health faculties at the Université d'Ottawa and Université Laval. The influence of Canadian professional training centers' ongoing affiliation with health-related faculties has not been investigated. This situation may contribute to continued use of vocabulary grounded in the medical model, language use that one author has described as sending the message that SLPs belong in health care (Soutar-Hynes, 1996).

The above timeline may fail to adequately convey the complexity of historical influences on speech-language pathology in Canada. Virginia Martin (2004) has noted that because professional training programs in Canada were slow to develop, all of the early (and significant numbers of the later) Canadian clinicians and faculty received their professional education in other countries, primarily in the United States and the United Kingdom. Additionally, she reported that the proportion of American- and British-educated professionals varied significantly among provinces, resulting in uneven patterns of influence. Martin also reported vast differences among the provinces in terms of sites of practice noting, for example, that in 1969 over half of Manitoba clinicians were employed in the schools while the overwhelming majority of clinicians in other provinces were employed in medical settings. A final factor of significance is the considerable variability in the date of regulatory legislation in each province (Martin, 2004). As Martin noted, legislation means that professional qualifications are specified. Licensing of professionals also becomes mandatory under legislation and licensees must abide by code of ethics and scope of practice documents adopted by the professional associations/colleges. While legislation governing the profession was first passed in Manitoba in 1961 – the first of its kind in North America, similar legislation was not passed in Alberta until 2002. Indeed, at the time of this writing, only Manitoba, Alberta, Ontario, Saskatchewan, and New Brunswick had regulatory legislation in place. In all other provinces and territories, speech-language pathology was an unregulated profession. Although CASLPA acknowledges itself as the single national body supporting the needs and professional development of SLPs and audiologists, as late as 1982 the organization was representing less than half of all the professionals in the country (Martin, 2004) and, as an association not a regulatory body, CASLPA membership remains voluntary today.

The Profession of Speech-Language Pathology Today

The membership rolls of the professional associations, both national and provincial, provided a picture of the profession of speech-language pathology at the time of my study. In 2004 when I began stage one of my study, 3441 SLPs were members of CASLPA. All of the membership data for CASLPA was obtained through personal communication with Scott Kettles, membership coordinator. Because CASLPA membership is voluntary, the number of members undoubtedly underestimated the number of SLPs in Canada but it was not clear by how much. By 2006, the number of SLP members residing in Canada had risen to 3548 (S. Kettles, personal communication, March 5, 2007). No other statistical information was available from CASLPA to allow profiling of their SLP members by such attributes as highest degree earned, years of experience, or workplace.

Provincial regulatory college data were requested for Alberta, where the study was undertaken. All of the following data were obtained through personal communication with Joanne Daugherty, executive assistant for the Alberta College of Speech-Language Pathologists and Audiologists (ACSLPA). Seven hundred and forty-five SLPs were registered members of the ACSLPA when I began stage one of the study in 2004. By March 2007, the number of registered SLPs had risen to 864. These numbers should accurately portray the potential workforce as SLPs must be registered with ACSLPA to work in Alberta. In 2004, 87% of ACSLPA-registered SLPs had master's level training in their profession. By 2007 this had risen slightly to 89%. In 2004, 53% of ACSLPA-registered SLPs had received their second degrees (presumably masters) out-of-province. By 2007 this had fallen slightly to 47%. In 2004, 78% of ACSLPA-registered SLPs resided in urban areas. By 2007 this had risen slightly to 81%.

Examining what has been written about workforce issues helped flesh out the statistical picture of the profession. Two workforce issues became apparent during the literature review. Not only were concerns reported about a lack of professionals; job satisfaction and burnout issues were reported for practicing SLPs.

Availability of Professionals

Concern about an inadequate supply of SLPs has been present since the early days of the profession in Canada (Martin, 2004). Steele et al. (1996) noted that a 1988 federal/provincial advisory committee of health human resources attributed the inadequate supply of rehabilitation professionals in general to chronic shortages in the number of professionals and a continual expansion of service requirements based on demographic trends. These authors argued that staffing reductions as a result of severe cutbacks to the funding of health care in the mid-1990s meant that there was no longer a shortage of health care professionals for the available positions. Hagler (1997), in contrast, insisted that information on funding and hiring practices suggested that the supply of rehabilitation practitioners, including professionals and assistants, continued to be inadequate. Anecdotal reports from the Western Canadian provinces of longstanding SLP position vacancies and hiring difficulties reported by employers suggested that there was an inadequate supply of SLPs at the time of my study. However, there had been no recent provincial or national study of this issue so it was impossible to make unequivocal statements about a shortage of professionals or other potential factors that might be contributing to the hiring difficulties employers have experienced. Ultimately, questions about the adequacy of professional availability cannot be answered without careful consideration of the population requiring service, the nature of their needs, and what constitutes appropriate service. This type of analysis has never been done. More research into speech-language pathology human resources and capacity is a critical need. After all, the availability of professionals has a direct influence on the public's access to the service they provide. This influence has been confirmed by studies from the United States documenting links between shortages of qualified SLPs and diminished service delivery. Over 50% of respondents to the *ASHA 2000 Schools Survey* reported a shortage of qualified SLPs in their school districts (American Speech-Language-Hearing Association [ASHA], 2000a). Reported effects of this shortage on service delivery included increased caseload (80%), decreased opportunities for individual services (62%), and decreased quality of service (56%).

Job Satisfaction and Burnout

Concerns about the job satisfaction of SLPs have been increasing over the past 15 years. Studies from the United States have consistently reported high levels of stress and burnout in SLPs working in schools (Goldberg, 1993; Miller & Potter, 1982; Pezzei & Oratio, 1991; White et al., 2005). Contributing factors have included increases in the number of children identified with disabilities, funding cutbacks to schools, insufficient time available to meet the demands of the caseload, significant administrative responsibilities, increasing paperwork, and a lack of resources. The majority of respondents to the *ASHA 2000 Schools Survey* questions on SLPs' working conditions reported that their greatest challenges were burdensome paperwork (88%); lack of time for planning, collaboration, and meeting with teachers (81%); and large caseload (60%). Large caseload numbers have been found to affect job satisfaction and SLPs' perceptions of their own effectiveness as well as the type of intervention used and SLPs' ability to engage in collaboration with teachers (Cirrin et al., 2003, p. 165). White et al. (2005) affirmed that caseload and paperwork were stress factors for SLPs but noted that working with clients increased SLPs' overall satisfaction and was therefore important for offsetting negative aspects of their work.

In a study of Canadian SLPs working in a variety of settings, Potter and Lagacé (1995) reported that 76% of those surveyed were suffering from mild to moderate levels of burnout. Burnout was defined as a state of physical and mental exhaustion involving the development of negative job attitudes and a loss of concern for clients. Respondents reported significant stress resulting from shifts in the systems responsible for service delivery, lack of understanding of their jobs by administrators and other professionals, excessively large caseloads, and the need to work unpaid overtime to keep up with the demands of their positions. Speech-language pathologists working in the schools reported that the lack of guidelines for provision of services was a significant concern.

In the sole investigation of the job satisfaction of SLPs serving Canadian schoolchildren specifically, Kaegi, Svitich, Chambers, Bakker, and Schneider (2002) investigated job satisfaction and burnout of SLPs serving school-age children within Ontario and Alberta. The researchers selected these two provinces because service delivery was changing in both. As a province, Alberta appeared to be moving towards expanded services for school-age children while in the Ontario situation, school board amalgamation had resulted in cutbacks to services. Kaegi et al. conducted a survey of SLPs affected by these changes. Approximately half of all SLPs who responded reported suffering from burnout and approximately one-third were dissatisfied with their jobs. A significant difference between the two provinces was not found and the researchers hypothesized that this result related to the similar sources of stress noted by the respondents. On the average, SLPs reported working almost 20 hours per week in excess of what they were paid for and being overburdened by the size of their caseloads. The respondents were unanimous in reporting increased funding and staffing as key components to effective service delivery. They suggested that their situation could be improved by legislation leading to "speech-language pathology being a mandated service with consistent guidelines and adequate funding across provinces" (Kaegi et al., 2002, p. 132). While the limited sample prevents much generalization from Kaegi et al.'s results, their respondents' observations of the need for government mandates and consistent guidelines echoed those of the school SLPs who participated in the Potter and Lagacé study in 1995, suggesting that SLPs working with school-age children recognized that organizational and governmental policies significantly influenced their work and ultimately, their job satisfaction.

The Role of SLPs Serving School-Age Children

Dictionary definitions indicate that a "role" is a set of expected behaviors and functions performed. In practice, however, societal roles are often very complex. In organizing the information about SLPs and their practice, I initially struggled to fully conceptualize the role of SLPs serving school-age children. I eventually found myself better able to think about the nuances of their role by reflecting on my own role as a parent. One way of thinking about the role of parents is to consider the number, ages, and characteristics of their children. Parents may also subscribe to certain models that influence their role such as the parenting philosophies of Dr. Sears or Dr. Spock. There are definitely specific tasks that go along with being parents. Additionally, most would agree that the parenting role is often influenced by media-defined "hot" childrearing issues of our time. In the following section, I have taken these same considerations – number, age, and characteristics of children served, models, tasks, and current issues – and reviewed the information available about the role of SLPs serving school-age children at the time of my study. First, however, I provide some historical information on the role of SLPs in Canada.

History of the SLP Role

The role of the Canadian SLP has evolved over the years. In terms of the number, age, and characteristics of children served, a 1964 review of early speech-language services provided the earliest information. The review's author, Theresa Murphy, noted that when services began to be provided in the late 1930's in the Winnipeg school system, the caseload was approximately 125 to 150 and consisted mainly of individuals with voice and articulation problems as well as those who stuttered, had cleft palates or were hard of hearing (Murphy, 1964). The program was described as being principally directed towards children in the elementary grades, as this group was thought to respond more readily to treatment, and to severe cases in junior and senior high. Murphy noted that cerebral palsy cases were accepted in 1949 and language disorders were added in 1952. By 1964, with increased staffing and the advent of a more interdisciplinary service delivery model, caseloads were reported to have decreased to between 50 and 70.

Historical descriptions of practice were uncovered that suggested that a split between health and education models had been part of the profession's discourse since its earliest days. In a memoir published in the *Canadian Journal of Speech-Language Pathology and Audiology*, Angela Murphy (1989) noted that Children's Hospital Speech and Hearing Services in Winnipeg began operating in 1951 using a "slightly modified medical model" (p. 34). Murphy described annual diagnostic clinics provided to rural areas that were sponsored by the Manitoba Society for Crippled Children. In contrast, Murphy's 1964 description of the evolution of services in the Winnipeg school division documented the creation of the Child Guidance Clinic of Greater Winnipeg in 1951 as bringing together in "special educational services" the department of Speech and Hearing, Psychiatry, Psychology, Social Work, and Remedial Reading.

In terms of the tasks of SLPs, the 1952 thesis of Isabel Richard, a pioneer in the profession in Canada, urged that record keeping be considered an integral part of the provision of speech-language services (Martin, 2003a). Richard's vision was of a record keeping system that would provide a picture of the child from the time therapy was initiated until the final disposition of the case, permit the transfer of cases from one therapist to another without waste of time and duplication of information, provide recorded information on cases so that a report can be compiled whenever it is requested, and make facts and figures available to administration in order to ensure continued growth of the program. Richard concluded that the record keeping should not be a burden to the SLP but should ultimately increase the clinician's work efficiency and that of coworkers.

But what activities would SLPs have recorded? In her 1964 retrospective, Theresa Murphy described the following activity schedule for SLPs working at the Child Guidance Centre of Greater Winnipeg: "Therapy is done in the assigned schools during five half-days of the week and in the Clinic centre for one half-day. In addition, testing and assessment, coordination and supervision, counseling and interpretation, and staff meetings each occupy one half-day per week" (Murphy, 1964, p. 6-7).

Collaboration with other professionals as part of the SLP role has been an ongoing theme. While Theresa Murphy's description of the 1951 formation of the Child Guidance Centre of Greater Winnipeg provided the earliest example, a 1983 report from the University of Alberta Speech Pathology and Audiology Department provided the most detailed early analysis of this component of the SLP role. *Rehabilitation Teams: Actions and Reactions* (Boberg & Kassirer, 1983) sought to improve quality of health care by promoting awareness of the expertise of various rehabilitation professions. The report featured a number of contributors discussing the characteristics of their professions, their profession's interaction with other disciplines on rehabilitation teams, and the link between these interactions and quality of care. The editors noted that lack of understanding about the expertise of other professions and lack of collaborative skills stemmed in part from professional training programs which provided students trained within one professional faculty with only superficial contact with students in other faculties. They observed that many new professionals found themselves floundering in role conflicts and expectations during their first years of practice as a result and emphasized that professional inability to capitalize on opportunities for collaboration with other professionals was a significant barrier to increased quality of care.

In the late 1970s and early 1980s, the Department of National Health and Welfare brought together a group of experts consisting of 11 SLPs and audiologists, all members of the Canadian Speech and Hearing Association; two otolaryngologists, one representing the Canadian Medical Association, and the other representing the Canadian Otolaryngological Society; one dentist representing the Canadian Dental Association; and one medical sociologist from the Department of National Health and Welfare (Minister of National Health and Welfare, 1985, p. ix). In response to concerns expressed by provincial governments and others, this group eventually produced a final report entitled *Guidelines for the Practice of Language-Speech Pathology* (sic) *and Audiology*. The use of the new term *language-speech pathology* was deliberate and represented the group's attempt to both preserve the identity of the label speech pathologist and emphasize the relatively new notion of the pre-eminence of language involvement in communication disorders. The final report included prevention, evaluation, treatment, and management of language, speech, and voice disorders as part of the role for the "language-speech pathologist." Emphasizing that these professionals worked collaboratively with others, the report noted that these collaborations were sometimes formalized into interdisciplinary teams. The report also stated that "language-speech pathologists" might take roles in university teaching, in research with both normal and pathological populations, and in management (Minister of National Health and Welfare, 1985, p. 5).

Indeed, the variation in specialization and function among "language-speech pathologists" which saw some members of the profession primarily engaged in screening programs for the detection of communication disorders, others in general clinical practice with a varied caseload, some in practice in one or more specific disorder areas or exclusively in parent counseling, and still others in educational and research activities was recognized by the expert group and influenced the composition of their proposed guidelines. The group noted that the areas of specialization did not represent hierarchical levels of competence although involvement in some areas might require a specialized educational background and/or additional professional training. They went on to acknowledge that interaction among the various clinical areas and clinical functions was commonplace (Minister of National Health and Welfare, 1985, p. 13).

The final report called for a renewed focus on primary prevention in three areas: developmental disorders, preventable organic or medical conditions, and environmental stressors. In addition to mass screening, other recommended early identification and intervention strategies included: public education regarding early signs of communication disorders, referral information, and availability of services; professional education for health care and education personnel regarding identification and intervention strategies as well as referral patterns; and specific educational programs for parents of children at risk for communication disorders (Minister of National Health and Welfare, 1985, p. 9).

The expert group developed consensus guidelines for diagnosis and treatment of communication disorders, which were classified into a five-fold taxonomy constituting: articulation, voice, resonance, fluency, and language (Minister of National Health and Welfare, 1985, p. 1). The guidelines on evaluation were said to reflect the general approach to evaluation of a patient with a communication disorder and included objective recording of the behavior status, case history interview, statement of evaluation procedures, rationale for evaluation approach, rationale for diagnostic labels used, rationale for additional consultation, prognostic statement, and recommendations. The group also discussed specific diagnostic measures of various disorders and included standardized and non-standardized approaches. In their discussion of treatment procedures, the group encouraged consideration of the following factors prior to the recommendation and implementation of treatment: the anticipated relevance of the therapy to the disorder; the expected effectiveness of therapy; its feasibility in view of the physical, emotional, and social status of the patient; and the motivational level of the patient (Minister of National Health and Welfare, 1985, p. 29). They also recommended that their process guidelines be supplemented by outcome measures.

Specific challenges to Canadian practice were recognized by the expert group and these suggest additional tasks for Canadian SLPs. The expert group noted that diagnostic and treatment materials for clinical practice were not readily available in French or in other languages spoken by significant proportions of the Canadian population, suggesting that SLPs would be responsible for adapting materials and perhaps even for developing and standardizing new materials. In a related item, SLPs were advised to carry out evaluations in a client's first language whenever possible. The expert group also acknowledged that practitioners in northern and other remote geographical areas of Canada might find it impossible to provide the same services as those recommended in urban situations, suggesting that accommodating services to the practice context was part of a SLP's role.

Also in 1985, Lafargue and Vowels reported on the workload evaluation for a SLP providing service to patients of a health region in central Newfoundland. Their report was the only Canadian workload analysis example identified and so was considered in detail despite its age. The SLP participant provided services at a clinic and also conducted 11 one-day visits to satellite clinics during the five month study period. Forty percent of the clinician's caseload consisted of school-age children with 47% being preschoolers and the remainder being adults. The first phase of the study identified the types of tasks conducted by the SLP, whose role within the department was largely clinical with limited administration duties. Four major categories of duties were identified. Thirty-seven percent of the SLP's time was spent on "direct patient contact", 34% on "non-direct-contact patient-related work", 19% on "departmental work", and 10% on "education and professional development". Each category was broken down into several subcategories as displayed in Appendix A.

Analysis of workload/time management was carried out at the end of the five-month period to obtain average values. Some variations were noted between individual months, but it was felt that overall averaged figures reflected numbers sufficiently reliable to reconstruct a "typical" work week for a SLP at the institution. The SLP recorded an average of 3.4 patient contacts per day or 17 per week. Six patient contacts were recorded on average for each visit to a satellite clinic. The authors noted that the higher number of patient contacts was warranted to provide service to the region, but that for every day spent at those clinics close to another full day of office work was generated for the clinician.

Almost as much time was spent by the SLP in non-direct-contact patient-related work as in direct contact time. Report writing was the largest time consumer in the non-direct-contact category. The SLP spent an average of 2 hours and 45 minutes to compile monthly statistics. An average of 9 minutes per working day was spent recording the data in the manner used in the study. The authors acknowledged the data entry and compilation as time consuming but felt that this was due to a lack of computer programs and hardware.

The authors noted that some of the subcategories had been condensed. "Correspondence" referred to telephone calls and letters, both incoming and outgoing, "preparation for therapy" included making therapy materials and communication aids, gathering necessary items, reading reports from other professionals, checking equipment and cleaning up the therapy room after each patient (Lafargue & Vowels, 1985). They also noted that counseling most often occurred after therapy sessions and as a result was often recorded as direct client time and advised considering scheduling as non-direct-contact patient-related work instead of departmental work.

As the sole Canadian workload analysis, the Lafargue and Vowels (1985) study provided the only information available to suggest the tasks engaged in by front-line SLPs serving school-age children. It must be noted, however, that in contrast to the participants in my study, the clinician studied by Lafarge and Vowels worked mostly in clinic; not traveling out to schools the majority of the time. Differences between Lafargue and Vowels' representation of front-line practice and that obtained in my study were therefore anticipated.

Number, Age, and Characteristics of Children Served

As the label most often used for the group of individuals they are responsible for serving, *caseload* is a critical concept for SLPs and those concerned about their services. Each SLP's caseload is typically described according to the number, age, and characteristics of the individuals served. In this section, I have first outlined what was known about the caseloads of SLPs serving Canadian schoolchildren at the time of my study, then, due to the scarcity of Canadian information, followed up with additional data from the United States.

Canadian Caseloads

Results of two investigations provided insight into the caseloads of Canadian SLPs serving school-age children. Dohan and Schulz (1999) investigated the characteristics of Canadian school SLPs and the status of classroom-based delivery of speech-language services in Canada. They obtained 253 usable questionnaires from SLPs working in schools across Canada (82% response rate). Twenty-one percent of respondents served 50 or fewer students, 37% served 51-100 students, 17% served 101-150 students, and a full 25% of respondents served over 150 students. The mean caseload size was 95 students with a range from 10 to 500. Dohan and Schulz concluded that the large range was likely a result of the respondents' differing interpretations of the question and of the varying factors that determine caseload size including SLP to student ratios, severity of student disorders, number of schools served, and travel time between schools. Eighty-nine percent of respondents provided services to students in kindergarten to grade three and 88% of respondents provided services to students in grades four to six. In contrast, 63% of respondents served students in grades 7 to 9 and only 46% provided services to students in grades 10 to 12. When respondents provided services to students in all four grade ranges, the vast majority of time was allocated to kindergarten to grade three students.

The most recent information on the number and age of children served came from the final report on CASLPA's 2003 *Caseload Guidelines Survey* (CASLPA, 2003). The survey was conducted to determine average caseloads in various work settings for CASLPA members serving clients of various ages, information needed to assist CASLPA board members in developing caseload guidelines. Unfortunately, the report was difficult to interpret because sampling of members from different provinces was not specified and the data provided by the 623 SLPs surveyed was substantially recoded. For example, respondents had been asked to indicate their active caseloads in one of three formats: caseload per week, per month, or per year. Wherever possible, data was recoded into monthly format. That this recoding could lead to overestimation of monthly caseloads in some cases was noted by the author of the report. No information was provided, however, about how much data required recoding.

Speech-language pathologists working for at least part of the time with children aged six and up made up 44% (275) of the survey respondents (CASLPA, 2003). In the area of caseload size, only data from 167 respondents who were working full-time and who spent the majority of their time with children over the age of six were included. The average number of cases carried per month by these respondents was 65, much higher than the average number of cases reported by other respondents working predominantly with young children (46) or adults (37). The average increased even more to 78 cases per month when only the respondents who worked completely with children over six were included. While the specific numbers may be somewhat inaccurate due to the recoding of data, if the recoding affected each pool of respondents equally the relative differences in caseload sizes across populations served should be representative of the actual situation in the field.

Survey participants were also asked to recommend an appropriate monthly caseload size. Fifty percent of the 167 SLPs working full-time mainly with school-age children recommended monthly caseloads of less than 40, considerably lower than their actual caseloads. To appropriately serve their clients, only 10 (6%) of these respondents recommended monthly caseloads at or above their current average of 65. Additionally, only 26% of respondents working mainly with children over six years of age were provided with caseload guidelines by their workplaces in contrast to 41% of respondents working mainly with preschool children.

Review of the two studies described above suggested that caseload was, in actuality, somewhat of an amorphous concept in Canada. The researchers appeared to assume that *caseload* was a common professional term with a singular, shared meaning. However, their difficulties interpreting the wide range of results obtained implied that the term may have been applied in a variety of ways by their participants. The information obtained by these studies suggested that average Canadian SLPs serving school-age children carried a caseload significantly higher than fellow SLPs working with other age groups and higher than that which they believed would allow for appropriate service to clients. Their caseloads also appeared to be focused predominantly on younger school-age children. Other than grade placement, no information was provided on the characteristics of children served.

American Caseloads

Recent information from the United States suggested that average monthly caseloads for SLPs serving school-age children were likely smaller than those in Canada although still considered large by the professional community. The *ASHA 2000 School Survey* found that the average monthly caseload of school-based ASHA-certified SLPs was 52, with a range from 15-110 (ASHA, 2000a). In their *2004 Schools Survey Report: Caseload Characteristics,* ASHA noted that this Schools Survey version melded topics from both their former omnibus surveys and previous schools surveys. The 2004 report affirmed an average monthly caseload for school SLPs of 50 but did not provide a range.

The 2000 survey had detected an interesting trend in the age of students on American school caseloads (ASHA, 2000a). In 2000, 45% of the students served were between 6 and 11 years of age – a decline from 64% in the 1995 survey. The 2000 results indicated an increase in services to the adolescent age group. No information was available in the 2004 report to confirm whether this trend had continued (ASHA, 2004a). Anecdotal evidence suggested that Canadian school-age caseloads remained focused on students in the elementary grades.

It was interesting to note that like the Dohan and Schultz (1999) Canadian survey, the *ASHA 2000* survey documented a wide range of caseload sizes. Cirrin et al. (2003) acknowledged variation in the use of the term caseload in the United States, noting that while the term typically referred to the number of students with individualized education programs and individualized family service plans that school SLPs served through direct and/or indirect service delivery options, SLP caseloads in some school districts also included students who did not have identified disabilities and who received pre-referral intervention and other services designed to help prevent future difficulties with language learning and literacy (p. 157). As in Canada then, caseload appeared to be a challenging term in American professional discourse.

In terms of the characteristics of students served, O'Connell (1997) perhaps said it best when she wrote "Every communication disorder that finds expression in individuals from birth to the age of 21 years is represented among the population to be served by school programs" (p. xxi). Across the United States, school SLPs serve students from at least four different groups – those classified by the educational system as "speech-language impaired"; those with speech-language needs related to other disabilities such as autism, developmental delay, cognitive disabilities, learning disabilities, and the deaf or hard of hearing; preschoolers eligible for early entry services; and students receiving pre-referral intervention and other services designed to help prevent future difficulties with language learning and literacy. ASHA (1999) and Cirrin et al. (2003) noted that American SLPs were serving school-age children with more complex and severe communication disorders than in the past and therefore requiring more intensive, long-term interventions. Over the past 20 years, the caseloads of American school SLPs have become increasingly dominated by younger students with specific language impairment and older students whose similar problems have been re-categorized as language learning disabilities (O'Connell, 1997). Service delivery can be further complicated for students who are also English language learners (ASHA, 2004a; Moore-Brown & Montgomery, 2001). Harn et al. (1999) noted that the caseloads of American school SLPs were influenced by changes in the characteristics of the overall student population such as increasing cultural and linguistic diversity and distressingly large numbers of children at risk for academic failure because of family substance abuse, poverty, and domestic violence.

Students with speech or language impairments have been reported to make up approximately 20% of all American students identified with any disability (Cirrin et al., 2003) or over 1 million students in the 1996-1997 school year (Blosser & Neidecker, 2002). Moore-Brown and Montgomery (2001) noted that this number underestimates the population served by SLPs because it does not take into account all the students who have medical or educational disabilities that include communication disorders. The number of children with speech-language impairments has reportedly grown by more than 10% between 1990 and 1999 with numbers of students in virtually all other disability categories served by SLPs also showing large increases in the same time frame (Cirrin et al., 2003).

No comparable Canadian information about the characteristics of students receiving speech-language services could be found. Anecdotal reports suggested that a similar situation was occurring in Canada with SLPs pressured to serve more and more students from an increasingly broad range of disability categories and with more complex speech-language disorders. Issues related to increasing diversity and rising risk in the general student population have also been documented in the Canadian educational literature (Sample Gosse & Phillips, 2005).

Models

In speech-language pathology, service delivery models are used to structure front-line practice. Service delivery models provide a way to consider how to best use intervention settings, providers, and resources to maximize the opportunities for individuals with communication disorders to acquire the skills they need to participate in important life contexts (Nelson, 1998). Models have typically been categorized according to the setting in which the intervention is delivered, the direct and indirect roles that the SLPs assume as they deliver service, and the facilities, personnel, instructional materials and service schedules (Cirrin & Penner, 1995). A review of the literature on speech-language pathology service delivery models in Canada provided information in two areas: use of "generic" service delivery models and the concept of an "education model" of service delivery. Issues and concerns around each of these two areas were uncovered and have been addressed below.

Generic Service Delivery Models

The label "generic" may be applied to service delivery models which specify in only a general sense the services provided by a SLP. For example, "itinerant program - direct service" is a generic label that has been used for a service delivery model in which the SLP travels to more than one school to provide program development, management, coordination, evaluation, and direct intervention services to students with a range of communication disorder types and severities 2-5 times per week (Moore-Brown & Montgomery, 2001, p. 138). In contrast, the "consultation program - indirect service" label has been used for a service delivery model which also includes direct program development, management, coordination, and evaluation services for a variety of cases but in which intervention services are indirect; the SLP develops clinical programs to be carried out by others (Moore-Brown & Montgomery, 2001, p. 138).

CASLPA's 2003 *Caseload Guidelines Survey* provided the most recent information on generic service delivery model use in Canada. Eighty-one percent of the 197 respondents who served mainly children over six years of age used more than one service delivery model (CASLPA, 2003). In fact, 67% used three or more models. The four most common models were consultative (85%), direct service to one client (83%), direct service to groups (65%), and collaborative (55%). The consultative model was described as the SLP determining the intervention targets, procedures and contexts, but relying on another agent of intervention to carry out the programs (CASLPA 2003). It was unclear why direct service to one client and direct service to groups were considered separate models as that differentiation is not typically made in the practice literature. No definition for collaborative service was provided, leaving questions about how it would differ from the consultative model or whether it referred to or included classroom-based interventions.

This type of confusion about generic service delivery models is not uncommon. Blosser & Kratcoski (1999) questioned at length the meaningfulness and utility of generic service delivery models. They noted that these models have traditionally been presented as discrete programs with unique characteristics. A hierarchy is often perceived in listings of the models based on factors such as frequency of services, location of services, and amount of direct contact between the SLP and client such that clinicians perceive that one service delivery option is "better" than another or that some models are more applicable to particular settings (such as schools) than others when that is not the intention. Another issue is that generic models have proliferated over the years with labels focused either on the activities performed by the SLPs (i.e., consultation) or on the context for delivery of the service (i.e., classroom-based or community-based) but with little consensus concerning their definitions and with the specifics of intervention remaining unclear. These problems have resulted in a situation where the generic service delivery model labels may be commonly used by professionals but interpreted in many different ways in practice. For example, for one clinician, *classroom-based* may imply that the clinician works with a student on classroom materials although for another clinician the term may be used to refer to collaborating with the classroom teacher. Little or no attention has been given to providing clinicians with information on which service delivery models may best meet the needs of individual clients. Blosser and Kratcoski (1999) argued that as a result of these issues generic service delivery models have limited instead of expanded SLPs' thinking about how to develop appropriate treatment programs. In a follow-up article in 2002, Blosser and Niedecker called attention to another issue with the use of generic service delivery models – educators are not typically aware of the definitions of the service delivery models used by SLPs, resulting in confusion and misperception about the type of service to be provided, the reason that model was selected, and the appropriateness for the particular student (p. 164).

Indeed, speech-language pathologists responding to the CASLPA survey (2003) were less than fully satisfied with their generic service delivery models. Only 62% of SLPs working mainly with older children reported satisfaction with the service models they were using. Their comments, however, were summarized as indicating that caseload size, not choice of service model, was their main problem. Specific concerns included reliance on parent and teacher support and insufficient time for follow-up in the consultative model and frequency of sessions for the direct service models. It was unclear then whether the issues related to generic service delivery models noted by Blosser and Kratcoski (1999) and Blosser and Niedecker (2002) were evident and problematic for Canadian SLPs.

Education Model of Service Delivery

While the CASLPA (2003) study provided information on the number and types of generic service delivery models used by SLPs in Canadian schools, other sources suggested that a concept of an education model of service delivery existed in Canadian professional discourse. In her investigation of the delivery of speech-language services to Ontario schoolchildren, Soutar-Hynes (1996) discovered that the SLPs who participated in the process conceptualized what she called an "education model" of service delivery based on their professional experiences and the evolving literature. These SLPs considered the "health model" to involve consultation in the schools on a case by case basis and provision of isolated treatment conducted without understanding of the curricular framework and limited rapport with education personnel. In contrast, they described the education model as involving SLP participation in multidisciplinary teams and educational in-services and with services focused on early intervention and awareness of the educational directives, curriculum, and social expectations of the schools. The SLPs discussed with Soutar-Hynes (1996) the "need to develop, collaboratively with educators, a model of human communication and education and a 'common conceptual frame,' a language of learning and teaching that deals with human communication and encompasses oral language and literacy, social behavior, and so forth" (p. 112).

Soutar-Hynes' (1996) completed a partial review of the literature on service delivery to school-age children, most of which originated in the United States, along with anecdotal comments from stakeholders. She ultimately concluded that the most appropriate model for speech-language service delivery to school-age children was an education model featuring SLPs as full participants in the educational process providing assessment, direct service, and consultation to other team members and system-wide projects. In addition, she concluded that such comprehensive and education-focused service provision was not feasible in the health setting. She did not, however, justify this conclusion.

Could any evidence be found showing this "education model" in action? Dohan and Schulz (1999) provided some evidence that Canadian SLPs were providing services in classrooms. Using a questionnaire, they captured information on respondents' personal characteristics, features of existing speech and language services, percentages of total assessment and intervention time spent in classrooms, the use and judged success of seven classroom-based intervention approaches, and the perceived advantages and disadvantages of classroom-based intervention approaches. They reported that "approximately three-quarters of respondents provided some assessment, intervention, or both in classrooms" (p. 11). When classroom-based services were provided, respondents spent approximately 40% of their time on classroom-based assessment and intervention. When the information on the use and judged success of seven classroom-based approaches was considered, Dohan and Schulz concluded, however, that approaches requiring less rather than more collaboration with classroom teachers were more likely to be utilized. For example, SLPs were likely to observe students in classrooms and assist students with work assigned by their teachers. They were less likely to engage in various forms of teaching within the classroom. Dohan and Schulz also found that factors such as gender, years of school SLP experience, teaching experience, possession of a bachelor's degree in education, possession of a master's degree in speech-language pathology, certification status, and caseload size were unrelated to SLPs' use of classroom-based approaches. They did not consider whether SLPs' conceptualization of an education model of practice was related to their provision of classroom-based services or, more significantly, to their use of more collaborative classroom-based approaches. This omission may have been due to the researchers' apparent understanding of all SLPs serving school-age children as "school SLPs", a term commonly used in the American literature to refer to SLPs employed by school districts. While all of the surveyed SLPs worked in school settings, Dohan and Schulz did not differentiate between SLPs employed by health and education and were therefore unable to offer any conclusive information as to whether SLPs' use of classroom-based approaches to service delivery was related to their employment situation. They did allude to this possibility by suggesting that provincial differences in time spent on classroom-based interventions might be related to whether services were provided under the auspices of health or education. No evidence was provided to tie a particular style of service provision by SLPs in schools to their employment in health versus education settings.

Burnett (2003) included SLPs as participants in her study of the challenges faced by Ontario rehabilitation therapists in serving children with physical disabilities in inclusive settings. Burnett's participants came from public education, public health, publicly funded private, and private employment settings and, as a result, served school-age children either in schools, clinics, or the children's homes. Each therapist had a range of contact with the school environments of the children they served. Regardless of their employment settings, all participants expressed significant concerns about the ability of public services to meet the needs of Ontario schoolchildren with physical disabilities as they were structured at the time of Burnett's study. Burnett described "the number of individuals the therapists encountered, the degree of commitment to exceptional students, and the existent or nonexistent channels of communication" (p. 65) as creating a complex work environment. The common failure to provide appropriate space within schools for rehabilitation services was viewed by Burnett's participants as symbolic of a broader failure to fully realize the ideal of collaborative educational/rehabilitation teams. Burnett described "unrealistically heavy schedules, insufficient time, multiple work sites which included travel time" (p. 202) as all contributing to therapists' difficulty in coordinating their work with that of educators.

In summary, the Soutar-Hynes (1996) review indicated that a segment of Canadian SLPs acknowledged a distinct "education model" for delivery of services to school-age children. Dohan and Schultz (1999) in turn found that Canadian SLPs were exploring classroom-based service delivery options. Neither study probed for possible links between employment situation, SLP conceptualization of a so-called "education model", and front-line service delivery practices. Both studies were also dated, raising questions about whether their findings would be consistent with the current practice situation. A more recent study conducted by Burnett (2003) appeared to suggest that rehabilitation therapists, including SLPs, were struggling to realize collaborative relationships within the Ontario educational environment regardless of whether they were employed by health, education, or privately.

Tasks

As is true of any role, the role of a SLP working with school-age children has particular associated tasks. The appropriate completion of any task is always dependent on having certain background knowledge. In the following sections, I have reviewed information available on the tasks and knowledge requirements associated with the general practice of speech-language pathology in Canada and also with the more specific practice of SLPs serving schoolchildren. Once again, I have also summarized information from the United States that provided more specific examples of practices for SLPs serving school-age children.

Current Canadian Practice

General practice documents from CASLPA provided the most current information available on the work tasks of Canadian SLPs. The *Scope of Practice in Speech-Language Pathology and Audiology in Canada* (CASLPA, 1998) was intended to inform employers, other professionals, and the general public of the range of activities that SLPs and audiologists can provide. For SLPs, it specified screening, identification, assessment, interpretation, diagnosis, management, rehabilitation, and prevention of speech and language disorders as appropriate tasks along with the assessment, selection and development of augmentative and alternative communication systems and provision of training in their use; the provision of counseling and education services to families, caregivers, and others regarding all aspects of communication and swallowing disorders; provision of aural (re)habilitation and related counseling services to hearing impaired individuals and their families; enhancement of speech-language proficiency and communication effectiveness, and screening of hearing and other factors for the purpose of speech-language evaluation and/or initial identification of individuals with other communication and swallowing disorders. Finally, education and supervision of students and other professionals and consultation with and referral to other professionals were mentioned as SLP tasks.

More detail on expected SLP tasks was gleaned from *Assessing and Certifying Clinical Competency: Foundations of Clinical Practice for Audiology and Speech-Language Pathology* (2004a). This standards document outlined knowledge that entry-level SLPs were expected to have and practices in which they were expected to be competent. It specified prevention, evaluation, client management, reporting, and professional behaviors as principles of clinical practice and professional practice issues. "Client management" was the term used to refer to the tasks that involved preparing and implementing an appropriate intervention plan. Under professional behavior, the document stated that "the SLP will demonstrate knowledge of the roles and functions of their professional associations, ethical practice considerations, responsibility and legal requirements regarding confidentiality of client information, effective self-evaluation and evaluation of intervention outcomes, personal responsibilities in continuing education, caseload management (selection of cases, referral, scheduling), and problem-solving and conflict resolution strategies" (CASLPA, 2004a, p. 27). In addition, specifics of assessment and intervention for developmental articulation/phonological disorders, neurologically based speech disorders, developmental language disorders, acquired language disorders; voice disorders, resonance disorders, fluency disorders, augmentative and alternative communication, hearing disorders and related speech-language disorders, and dysphagia (swallowing) disorders were noted.

The final report of CASLPA's 2003 *Caseload Guidelines Survey* provided the only source of even limited information about how Canadian SLPs serving school-age children were actualizing the tasks outlined in the afore-mentioned scopes of practice and standards documents. Anecdotal evidence suggested that SLPs working in schools were spending more time on assessment because it was required to get funding, and less time on actual service delivery. The report also summarized the comments of SLPs who emphasized that caseload – or number of students served - did not describe their full workload (CASLPA, 2003a). Additional tasks reported included training and supervision of assistants or volunteers, participation on multidisciplinary teams, conferring with teachers and parents, and continuing professional development. Extensive documentation demands were also noted.

Current American Practice

In March 1999, ASHA released the *Guidelines for the Roles and Responsibilities of the School-Based Speech-Language Pathologist*. In this document they responded to requests by SLPs, school administrators, lobbyists, and legislators to define the roles and delineate the responsibilities of the SLP within school-based speech-language programs. Fourteen major categories of responsibilities were identified – prevention, identification, assessment (data collection), evaluation, eligibility determination, individualized education plan (IEP) development, caseload management, intervention, counseling, re-evaluation, transition, dismissal, supervision, and, documentation and accountability. Each category was broken down into several subcategories as displayed in Appendix A. The Guidelines document (ASHA, 1999) also specified additional roles and opportunities for school-based SLPs in the areas of cooperative community and professional partnerships, professional leadership (i.e., specialization, mentoring), and advocacy for students with communication differences and needs. While ASHA's Guidelines document was not based on a study of the actual practices of SLPs serving schoolchildren as were the Canadian studies reported on previously, ASHA utilized a volunteer panel of experienced school-based SLPs and administrators to assist with preparation of the document. As a result, although the resulting document may not have portrayed the actual tasks of all American school SLPs in 1999, it provided a picture of what the American SLP community supports as appropriate tasks for school SLPs at that time.

In terms of the time school SLPs spend on various tasks, *ASHA 2000 Schools Survey* found that 2133 ASHA-certified school-based SLPs spent an average of 6 hours per day on direct contact with students (ASHA, 2000a). In a typical week, approximately 70% of their time was spent providing direct intervention and diagnostic evaluations. The other 30% was spent in other work-related activities including record keeping, paperwork and report writing; planning and preparation for intervention; and parent and staff meetings.

In the same year as ASHA's Guidelines document was published, Harn, Bradshaw, and Ogletree (1999) published an organization of the various tasks of school-based SLPs into the multiple roles represented, noting that an individual SLP would often serve multiple roles within a single educational setting. The roles and associated tasks they delineated were as follows:

1. Direct service provider – Providing direct service to at least some of the children on their caseloads. Moving more into classroom-based service from individual or group pull-out service.
2. Collaborator/Consultant – Interacting with other professionals (e.g., classroom teachers, special educators, reading specialists) and parents in one or more of the following activities: observation, goal setting, consultation to discuss and plan intervention objectives, and collaborative delivery of intervention services. Serving as a member of a multi-, inter-, or trans-disciplinary team.
3. Supervisor: Supervising SLP assistants. Defining the role of assistants within the service delivery system

These authors also noted that SLPs must possess an increasingly broad range of competencies in order to practice in today's schools where the student population has a greater variety of and levels of severity of disabilities and is more diverse culturally and linguistically. They discussed how the push to deliver curriculum-based language interventions had meant that SLPs needed to be familiar with their school's curriculum and the demands of the curriculum on students' language and communication skills. Harn et al. (1999) also argued that school SLPs must also understand the links that exist between skill developments in spoken and written language and those that exist between preschool language impairments and school-age learning disabilities.

Indeed, for the past number of years, American school-based SLPs have been strongly encouraged to apply their specialized expertise in oral language development to the provision of prevention, assessment, and intervention services in the areas of reading, writing, and spelling (ASHA, 2001a, 2001b; Apel, 2002; Ehren, 1999). ASHA (2001b) outlined roles for SLPs in preventing written language problems by fostering language acquisition and emergent literacy, identifying children at risk for reading and writing problems, assessing reading and writing, and providing intervention and documenting outcomes for reading and writing. Additional roles in providing assistance to teachers, parents, and students, advocating for effective literacy practice, and advancing the knowledge base were also noted.

American school SLPs may be involved in tasks that are even more non-traditional. Moore-Brown & Montgomery (2001) described school SLPs as involved in additional responsibilities and tasks taken on voluntarily based on personal interests, because the previous SLP did them, because the school was short-handed, or because everyone took on extra duties to cover the territory. The list included such tasks as recess and bus duty, school play director, athletics coach, field trip assistant, and coordinating a particular fundraising activity (p. 289).

Based on this cursory review of the American literature related to the work tasks of school SLPs, it appeared that American school SLPs were expected to perform an expanded range of duties from those portrayed in the Canadian literature, although the most recent Canadian report suggested that SLP tasks were expanding (CASLPA, 2003). American school SLPs also appeared to spend the majority of their time engaged in direct client service activities which contrasted with the older Canadian information provided by Lafargue and Vowels (1986). The question of how similar the tasks currently undertaken by Canadian SLPs serving school-age children would be to those represented in the American literature remained unanswered.

Current Issues

As information on "hot" childrearing issues of our time can be sought in the popular media and parenting literature, information on the current issues facing SLPs serving school-age children can be sought in the professional literature. My review of the professional literature at the time of my study revealed three primary issues influencing speech-language service delivery to school-age children: caseload versus workload, extending services through the use of support personnel, and outcomes research/evidence-based practice.

Caseload versus Workload

For the past five years, discussions of the appropriateness of caseload versus workload measures and workload measurement systems have been prevalent in the American school speech-language pathology literature. Numerous newsletter and journal articles have appeared in ASHA publications and ASHA has in turn developed a position statement, guidelines, and technical report on the issue (ASHA, 2002a, 2002b, 2002c). The major premise put forward in these discussions has been that the total workload activities required and performed by school-based SLPs must be taken into account in setting appropriate and reasonable caseload standards (ASHA, 2002a). Traditionally, a SLP's workload has been seen as synonymous with caseload, or number of students served. Although caseload guidelines specifying the maximum number of students per SLP have been in place in the past in the United States, those proposing a change to a workload approach argue that these guidelines have failed to ensure caseloads that allow enough time for the provision of quality services. In a technical report, ASHA (2002c) presented data from their National Outcomes Measurement System (NOMS) demonstrating that student outcomes are influenced by caseload size; that is, Kindergarten through twelfth grade students on caseloads of fewer than 40 were more likely (87%) to make measurable progress than those on caseloads of 60 and above (63%). Cirrin et al (2003) also referenced the NOMS data as well as other studies as evidence that large caseloads have limited SLPs' available service delivery options to providing almost exclusively direct intervention services to students, primarily in groups rather than individually, regardless of students' individual needs. With the vast majority of the school day or week filled with direct face-to-face services to students, these SLPs would not have enough time left to perform adequately the many other activities and responsibilities required to meet the needs of students, implement best practices in school speech-language services, and be in compliance with federal, state, and local special education mandates (Cirrin et al., 2003).

Proponents of a workload approach argue that caseload is more accurately conceptualized as only one part of a SLP's total workload. Workload would encompass the time required for SLPs to complete paperwork and parent and teacher contacts and to serve on teams or as case managers for students on their caseloads. It would also include the time needed to supervise paraprofessionals and the time needed to serve students without identified disabilities who receive pre-referral intervention and other services designed to help prevent future difficulties with language learning and literacy. Despite the apparent intellectual promise of the workload analysis approach, it has been plagued by questions about its practical utility. For example, half of the participants in ASHA's 2004 School Survey indicated that they did not know about ASHA's workload position statements and a third knew about it but either did not find it useful or had not implemented it (ASHA, 2004a).

At the time of my study, however, the workload analysis approach appeared to be gaining momentum in the United States with articles (i.e., Cirrin, 2004; Moore, 2004), website postings (i.e., Cooper, 2006), and ASHA list-serve discussions centering on how to put the approach into practice. A movement to a workload approach should be bolstered by the fact that school-based SLPs were not the only American professional groups considering a change to a workload analysis system. Cirrin et al. (2003) had noted that discussions were also occurring among special educators, occupational therapists, physical therapists, child welfare workers, and teachers of the visually impaired. Is "caseload versus workload" an issue in Canada? As noted in an earlier section of this review, concerns about the size of Canadian SLP caseloads have been reported for years. The term workload may be coming to the awareness of Canadian SLPs as well. Those SLPs responding to CASLPA's Caseload Survey (CASLPA, 2003) emphasized that caseload alone did not describe their full workload, listing additional demands on their time. No information could be found, however, to suggest that workload analysis approaches similar to those proposed in the United States had been tried in Canada.

Extending Services Through the Use of Support Personnel

Because it has been an ongoing challenge to provide speech-language services to school-age children in an effective and efficient manner, there has been consistent pressure on Canadian service delivery providers and systems to develop and utilize various means of extending service provision. Support personnel are one means often proposed. Use of support personnel in speech-language pathology has been an issue in Canada since the 1980s. In 1988, the Federal/Provincial Advisory Committee on Health Human Resources considered the expanded use of support personnel as a potential solution to both the longstanding shortage of rehabilitation professionals and the need for cost-efficient expansion of rehabilitation services (Steele et al., 1996). Assessment and definition of specific training requirements, service functions, and supervisory conditions for support personnel were identified as being required prior to expanding their use. In 1991, an interdisciplinary research project at the University of Alberta was funded by the National Health Research and Development Program of Health Canada (Steele et al., 1996). The project was designed to investigate the training, use, and supervision of support personnel and explore options in these areas.

The results of the research project were published in *The Role and Use of Support Personnel in the Rehabilitation Disciplines* (Hagler et al., 1993). The research team had collected information by means of a survey of institutions employing support personnel and a review of the literature on the use of support personnel in other countries. Ultimate recommendations included the specification of appropriate job duties for support personnel, a proposal for a one-year generic college-level training program with both academic and clinical components, and minimum supervision standards.

The Hagler report was quite controversial in the Canadian speech-language pathology community. A committee charged by CASLPA with the review of the report made significant objections to the conclusions. The review committee argued that the report was based on several questionable assumptions, including that there was in fact a shortage of professionals and that support personnel would provide a cost-effective means of providing services (Steele et al., 1996). In addition, the costs of training support personnel at the post-diploma training level were thought to be incompatible with cost savings for the health care system. They were also concerned that generic training could not be specific enough to speech-language pathology to be effective and efficient. The committee questioned the feasibility of obtaining sufficient clinical training placements for support personnel given their observation of a shortage in professional training sites for master's candidates.

Paul Hagler, lead researcher for the University of Alberta study, responded to the CASLPA committee's objections to his team's report (Hagler, 1997). He stated that no data had been presented by the CASLPA committee to support their contention that there was no longer a shortage of rehabilitation service providers and that it was his impression that a shortage continued to exist. His team's recommendation for post-diploma training for support personnel was defended by arguing that on-the-job training for support personnel was an expensive endeavor and that pre-employment training would shift costs to the potential support personnel instead of the employer and result in more effective and efficient use of clinical resources. Hagler also emphasized that a cost-benefit analysis was not one of his team's responsibilities but would undoubtedly be a useful activity to undertake in the future. The provision of training generic to all rehabilitation professions was justified in terms of providing flexibility for employers and mobility for support personnel. Hagler argued against the committee's position that this type of training could not be specific enough to be effective and efficient. Throughout his submission, Hagler (1997) voiced strong support for the use of support personnel at one point writing that, "Whenever audiologists and speech-language pathologists find themselves doing something that doesn't require that expensive professional training, advanced degree, and professional credential, they ought to be asking themselves if that activity could be turned over to an assistant" (p. 6).

The position statement on the use of support personnel in speech-language pathology ultimately created by the CASLPA committee continues to stand today as an updated version has not been developed (CASLPA, 1995). The position statement indicates the association's support for the use of support personnel to enhance the services provided by fully qualified professionals and specifies that the ultimate responsibility for the services provided lies with the supervising clinician. It also specifies six activities that should be performed only by a fully qualified professional including interpretation of a referral, assessment, diagnosis, prognosis, or client performance; selection, modification, or termination of assessment methods, treatment procedures, or treatment goals; initial contact with the client; consultation with referral sources; administration of any assessment or treatment activities that may pose a risk to the client; and all discharge planning and reporting (CASLPA, 1995). The position statement affirms the professional role in determining which other activities are appropriate to delegate to support personnel and the level of on-the-job training required and emphasizes that the services provided by supervising clinicians must be considered in any determination of the efficacy of support personnel. In regards to school-based delivery of speech-language services, the position statement outlines only one specific scenario as follows:

> In situations where a speech-language pathologist or audiologist is contracted in a consultative role (e.g., school boards), support personnel may be used to enhance the delivery of intervention programs established collaboratively by the classroom teacher/consultee and the consulting clinician. The clinician supports the

> consultee (e.g., classroom teacher) who retains ultimate responsibility for the client/student. The consultee (e.g., classroom teacher) may delegate tasks to the support person, and may provide direct supervision to the support worker in conjunction with the consulting clinician (CASLPA, 1995, ¶ 4).

In my experience, this portion of the position statement has been particularly difficult for practicing professionals to interpret. Appropriate interpretation of responsibilities for programming provided by educational assistants seems of greater concern to clinicians than issues related to the use and supervision of designated speech-language pathology assistants. In 2004, CASLPA developed *Supportive Personnel Guidelines: Working with Speech-Language Pathologists* for those individuals entering a new membership category for support personnel. Unfortunately, this document was not designed to clarify specific situations related to the provision of speech-language services to school-age children (CASLPA, 2004b).

Outcomes Research and Evidence-Based Practice

Within the last 15 years the field of speech-language pathology has started to realize how little is truly known about what works in clinical care. This realization has spurred increasing interest in two trends within the provision of public services – outcomes research and evidence-based practice. Therefore, in addition to dealing with the potential emergence of an education model, workload/caseload issues, and new means of extending service delivery, those studying the delivery of speech-language services to school-age children must also consider the information available on how these two trends may influence the practice of speech-language pathology across settings.

Outcomes research involves careful consideration of the outcomes of interventions and the development of processes and tools to measure these results. Frattali (1998) noted that outcomes for intervention are often multiple, varying according to whose perspective is taken into account (i.e., clinician, administrator, client, family) and when measurement occurs (i.e., short-term versus long-term measurements). While efficacy research utilizes highly controlled experimental conditions to measure outcomes of treatment under ideal circumstances and permits statements of cause and effect, outcomes research involves quasi-experimental conditions to measure outcomes of treatment under typical circumstances and allows statements of trends and associations.

According to Frattali (1998), outcomes research is driven by clinical and scientific concerns related to the "search for knowledge about which interventions work and which do not, and which work better than others" (p. 30) and managerial concerns related to the need for "proof of value for dollars spent" (p. 29). Outcomes research appears to have gained prominence in Canada as concerns with the cost effectiveness of public services increased. Coyte (1992) noted that information about the benefits and costs associated with alternative clinical practices was needed to use resources allocated towards speech-language pathology effectively. A faculty member in the Department of Health Administration at the University of Toronto, Coyte observed that government limits on health expenditures do not specifically enhance the cost-effective provision of health care services. Government limits were described as focusing exclusively on the costs of health care while ignoring the benefit side. He argued that for both economics and ethics to be evenly weighted in the decision making process, information about the costs and outcomes of clinical practices and the value placed on the outcomes is necessary.

While Coyte affirmed the primacy of outcomes research in examining the effectiveness of clinical practice, he also urged continued consideration of structure and process. Frattali (1998) echoed this concern noting that "a preoccupation with outcomes measurement to the exclusion of linking outcomes to antecedent contributory inputs and processes leads to serious research design flaws and misinterpretations of study results." (p. 35). Coyte (1992) described the structure of care as stressing the "characteristics of providers and the institutions (or environments) in which care is delivered" (p. 278). Assessment of the structure of care would include evaluation of provider expertise, staffing ratios, and physical and organizational arrangements. Process of care was described as relating to how care was delivered to clients. Coyte demonstrated that assessment of structure and process addressed the inputs to client service while consideration of the outputs required outcomes research. While it would seem likely that some of these concepts are used by administrators to evaluate Canadian speech-language pathology programs, no documented instances of Canadian outcomes research in school practice settings could be found.

A second trend addressing the quality of service provided, evidence-based practice, or EBP, has been defined as "the integration of best research evidence with our clinical expertise and our patient's unique values and circumstances" (Sackett, Strauss, Richardson, Rosenberg, & Haynes, 2005, p. 1). Evidence-based practice is a perspective on clinical decision-making that has been described as a paradigm-shift in medicine and is now apparent in a variety of other fields. Speech-language pathologists have been encouraged to contribute to the knowledge base of the profession through evidence-based research and the use of evidence-based practices in their clinical services (Apel, 2001; Johnson, 2006). The American Speech-Language-Hearing Association has published a technical report on the subject (ASHA, 2004b). Some guidelines creation initiatives have begun in the United States, particularly in the area of neurologic communication disorders (ASHA, 2005). In November 2005, a registry of evidence-based clinical practice guidelines and systematic reviews of topics related to audiology and speech-language pathology was launched (ASHA, 2006). The Canadian Centre for Knowledge Mobilization has recently unveiled a catalogue of paediatric speech-language pathology reviews (Canadian Centre for Knowledge Mobilization, 2007), but at this point I am not aware of any Canadian initiatives specific to the development of evidence-based guidelines for front-line speech-language pathology service provision.

The Context for the Delivery of Speech-Language Services

It is clearly not enough just to consider the providers of speech-language services and their roles. After all, in the majority of cases, these providers simply do not have jobs and their roles cannot be enacted unless there are systems within provincial governments that take responsibility for providing the service to their populations. In a 2003 study of rehabilitation therapists, including SLPs, and their role in inclusive education, Dawn Burnett described her participants' struggles to direct their own practice within organizational controls and resource limitations. Burnett also noted that work setting was a critical factor with regards to therapists' job contentment and satisfaction, and hence the quality of service delivered. The fact that a model for delineating professional performance and competence had been proposed which placed competence as a prerequisite while noting that performance was also strongly influenced by factors external to the practitioner, including systems-related influences, served to further affirm the importance of context (Burnett, 2003).

In Canada, the systems responsible for speech-language service delivery vary among provinces. While comprehensive information on these systems was unavailable, national reports provided a glimpse into the context for the delivery of speech-language services. A review of reports published within the three provinces, Manitoba, Nova Scotia, and Ontario, where formal study of the delivery of speech-language services had taken place allowed further conceptualization of the issues. Finally, documents were obtained which allowed some tracing of the historical context for the profession in the province of Alberta, where this study took place.

A Glimpse at the National Scene

Guidelines for the Practice of Language-Speech Pathology (sic) *and Audiology*, the 1985 final report of an expert group commissioned by the Department of National Health and Welfare, was suggestive of a complex and varied Canadian service delivery context. First, in terms of policy and management, the introduction stated that the report was not a statement of federal government policy because the federal government's role was not to set policy but rather to assist in developing an information base from which policies could be developed at the provincial and local levels. The report also stipulated that it was neither the role nor mandate of the Department of National Health and Welfare to implement the guidelines and that the implementation would "vary provincially and regionally depending on human and material resources, and on policies and priorities of those provinces and regions" (Minister of National Health and Welfare, 1985, p. iii). Secondly, the Guidelines report identified several aspects of the Canadian context as representing uniquely Canadian practice needs. These included the need to develop and standardize adapted diagnostic and treatment materials for use with French speakers and the speakers of other languages spoken by significant proportions of the Canadian population, the need to develop means of carrying out evaluation procedures in a client's first language, and the recognition that procedures recommended for urban situations might be impossible to fulfill in northern and other remote geographical areas.

In 1988-1989, the CASLPA Demographics Committee undertook a nationwide survey of SLPs and audiologists and students studying in these fields as part of the 25th anniversary of CASLPA (CASLPA, 1990). This initiative was the first systematic and comprehensive survey of the professions undertaken in Canada. Results of the survey indicated that 56% of SLPs and audiologists completed their studies in Canada with 37% having studied in the United States. The highest proportion of professionals having graduated from American schools was found in Manitoba (83%) and Saskatchewan (68%). Because Manitoba and Saskatchewan continue to have no professional training facilities, it is likely that this trend continues today but no specific information is currently available on the overall proportion of Canadian SLPs trained in the United States.

The Demographics study (CASLPA, 1990) also found that school boards were the largest employer for SLPs in Western Canada (47%) with a range from 32% in Alberta to 65% in Manitoba. In contrast, hospital employment was more common in both Central and Eastern Canada (34% and 38% respectively). Overall, more than half (54%) of SLPs serving the school-age population were employed by a school board, while 21% worked at a hospital, 11% with public health and/or community services, 9% at a rehabilitation centre and 5% in private practice (CASLPA, 1990, p. 39).

An in-depth examination of service delivery was beyond the scope of the 1990 study. The committee noted that details on service delivery trends in Canada were lacking and recommended that measures be taken to conduct a national study. It was also the committee's hope that their report be viewed as a first step to be followed by "a thorough examination of the speech-language pathology and audiology services offered in each province and territory and the policies affecting those services" (CASLPA, 1990, p. 113) and government involvement to "study the nature and needs of individuals with communication impairments in Canada" (CASLPA, 1990, p. 139). Unfortunately, the committee's recommendations for ongoing study were not addressed, leaving their 1990 report to stand as the only comprehensive study of speech-language pathology and audiology services in Canada.

CASLPA's 2003 *Caseload Guidelines Survey* provided some current information about the working context of Canadian SLPs serving school-age children. Unfortunately, weaknesses in the survey implementation made it impossible to determine whether each province/territory was adequately sampled. That said, SLPs working with children aged six and up made up 44% (275) of the survey respondents (CASLPA, 2003). Nearly all of these SLPs were also seeing clients from other age groups. Thirty-six percent were also treating younger children while 11% had some adult clients. It was reported that only 6% of the SLPs responding to the survey were treating school-age children exclusively. However, it is quite possible that some of the 36% of respondents also serving children younger than six were serving five-year-olds enrolled in kindergarten or perhaps even four-year-olds in early entry programs.

Two-thirds of the 275 SLPs (67%) who served children aged six and up were working full-time. Eighty-one percent of the SLPs working mainly with children over six years spent some time working in schools while 40% worked in schools full-time. The respondents who worked full-time and spent the majority of their time with school-age children had an average caseload size of 65, much higher than the average number of cases reported by other respondents working predominantly with young children (46) or adults (37). Caseload size was the most common concern of SLPs working with school-age children. Speech-language pathologists working in rural areas noted that distance and isolation presented additional difficulties (CASLPA, 2003).

Manitoba Service Review

Of the provincial reports identified, the Manitoba one was the most dated, being published in 1986, but did provide sample strategies for considering speech-language services across a jurisdiction. The Manitoba report, *Assessment of the Provision of Speech-Language Pathology and Audiology Services in Manitoba,* was prepared for the Province of Manitoba Social Resources Committee by Patrick T. Alexander, Ph.D. consultant. Alexander (1986) states that the report arose from the Government of Manitoba's recognition of the overwhelming public support for an increase in speech-language pathology and audiology services and its need both for background information on services provided and for recommendations on how to proceed with service improvements. At the time, specific areas of public concern were the lack of preschool services, the inability of school programs to provide intensified treatment programs, and the difficulty of accessing services for adults including those who stuttered, were mentally challenged, or were hearing impaired.

In his review of the population requiring speech-language pathology services, Alexander (1986) noted that classification of individuals with speech and language disorders was typically based upon one or a combination of the following: grouping by age range, grouping by disease or medical condition, and grouping by speech and/or language disability. He acknowledged that consideration of age range facilitated examination of the disruptive effects of a speech and/or language problem on an individual's life. Disease/medical condition was recognized to be particularly important if an objective was to make programming decisions related to multidisciplinary care systems and speech/language disability was seen as the paramount consideration for measuring or predicting the workload of a SLP. Alexander incorporated all three classifications into his study. Individuals were initially considered according to age range (birth to 5 years, 5 years to 18 years, 18 years to 65 years, and 65 years and older), then according to whether a cause of their speech/language disorder had been attributed to a major disease or medical condition, and finally, according to their principal speech/language diagnosis (Alexander, 1986).

The anticipated speech-language service needs of school-age children were discussed. Alexander (1986) noted that school speech-language pathology services are required both by children whose speech/language disorders were not detected during their preschool years and by children who were identified during their preschool years but continue to have difficulty. Alexander also argued strongly for the importance of speech-language pathology services to the education of children with speech/language disorders, noting the negative impact of the disorders on children's learning potential. Describing the negative impact of communication disorders on children's understanding of spoken and written information and, therefore, on their ability to learn to read and write and to become independent learners, Alexander emphasized the need for "optimal integration of speech and language remediation with all regular and special education programs and activities in the school system" (1986, p. 8).

Mentioning a report published by ASHA in 1974 and authored by Healey, Alexander (1986) recommended a ratio of one SLP for every two thousand schoolchildren. Ratios for preschool children were more (1:1500) and ratios for seniors were less (1:5,000) while ratios for adults were significantly less (1:15,000 to 1:35,000). There is no discussion in the Alexander report of how these ratios were established and the original 1974 Healey reference could not be obtained for review. In any case, these ratios are not applicable today given current demographics and the changing health and communication needs of the population. It is most valuable to simply recognize the attraction to jurisdictions of planning services using staffing ratios, an attraction that continues today (see the discussion of the Nova Scotia service review later in this section). In addition, no evidence could be found that any jurisdiction in Canada had ever met the service ratios suggested by Alexander. At the time of his Manitoba study, provincial staffing levels were at 59% of the recommended levels across population age groups (Alexander, 1986).

Numerous categories of speech and language services required by Manitobans, including prevention, identification, assessment, treatment, and follow-up to prevent regression, were specified (Alexander, 1986). Necessary variability in the design of treatment programs to accommodate different types and severities of speech/language disorders was recognized. Alexander (1986) documented the different speech-language services provided under the auspices of government departments of Community Services, Education, and Health, which demonstrated the need for inter-ministerial collaboration. The importance of collaboration was further emphasized in the following recommendation on program organization:

> The community/social, education, and health aspects of communication disorders have combined effects upon the individual afflicted. They are intricately related perspectives on the capabilities of speech, language, and hearing impaired individuals. Services that isolate these aspects or attempt to deal with them separately lack effectiveness. In addition considering speech, language, and hearing problems as either community/social, or educational, or health problems can be extremely inefficient. (Alexander, 1986, p. 73)

Alexander also made it clear that he was in favor of formal cooperation between agencies: “Passive coordination of community, education and health services, or ‘unofficial’ cooperation of community, education, and health agencies will not accomplish optimal service delivery” (p. 74).

Manitoba’s Alexander (1986) report demonstrates historical support for considering the speech-language service needs of the school-age population as uniquely tied to the goals of the education system. It also strongly recognizes the complexity involved in meeting the needs of children requiring multidisciplinary support. While

Alexander listed categories of services and was the first Canadian author to specify service ratios, he also argued convincingly for flexibility in service. The impact of organizational and governmental policy on speech-language services was highlighted by Alexander, who strongly urged more formal cooperative agreements.

Nova Scotia Service Review

While the Nova Scotia project was a one-time service review, the project's final report provided the most recent summary of services in other provinces. In April 1995, the Nova Scotia Speech-Language Pathology Working Group was convened through a directive by the Deputy Ministers of Health and Education and Culture and charged with the investigation of publicly-funded speech-language services in the province (Government of Nova Scotia, 1997). The Working Group noted that, at the time of their study, the Nova Scotia Hearing and Speech Clinic provided speech-language services to preschool children and adults, while the regional school boards were responsible for services to school-age children and youth in the public school system. Similar splits in responsibility for service provision were found in five of the eight provinces surveyed by the Working Group. The governments of British Columbia, Saskatchewan, Manitoba, and Newfoundland all indicated that their Health ministries were responsible for providing speech-language services to preschoolers and adults while their Education ministries were responsible for providing services to school-age children. The government of Ontario provided information on a tri-ministerial agreement between their Health, Community and Social Services, and Education ministries. In Alberta, New Brunswick, and Prince Edward Island, the Health ministries were responsible for providing speech-language services to their entire populations. It is important to note that "responsibility for providing services" had very different meanings across provinces. In many cases, services were not mandated and levels of service were not specified.

The Working Group was asked "to develop a framework identifying the mandate, structure, and funding for the integrated delivery of government-funded Speech-Language Pathology services to all Nova Scotians" (Government of Nova Scotia, 1997, p. 2). To refine their thinking about the task set out for them, they drafted a vision for the future model of speech-language services. They specified that the model should result in consumer-focused, effective, and efficient speech-language services being provided in appropriate settings. A comprehensive and coordinated range of services was seen as necessary to provide flexible options with respect to the consumers' needs and the context within which service would be provided. They recognized a need to ensure accessible and equitable services for all Nova Scotians. Attention to public and consumer education and the development of collaborative relationships among care providers was regarded as critical as was the development of a service that was accountable to consumers, referral sources, service providers, and funding sources. While the Working Group's vision included many important considerations, they were more generic to public services. The considerations outlined in the vision were not specific to speech-language services nor were they based on recommended practices in speech-language pathology.

By March 1997, the Working Group had conducted a literature search, compiled their proposed vision and objectives for speech-language services, reviewed the current structure of service delivery in Nova Scotia and in other provinces in Canada, and identified the strengths and weaknesses of the current system. The Working Group also conducted focus groups of consumers and providers of SLP services and accepted written submissions from groups or individuals. An independent research firm was engaged by the Department of Education and Culture to analyze and report on the information gathered from the focus group meetings and the written submissions.

Areas of service strength identified at the time of the review included the year-long and standardized clinical services provided by the Nova Scotia Hearing and Speech Clinic and the specialized educational knowledge and on-site, in-community service provided by SLPs employed by the regional school boards. Participants in the focus groups and those who made submissions emphasized the importance of speech-language services to individuals and families and praised the quality of services received. Particular support was also given to the provision of speech-language services in the schools. Integration of services with the curriculum and improved access to services were cited as benefits of school-based speech-language services.

Weaknesses of the service delivery system at the time were found to relate to under-funding, with provision of the services below recommended levels and variations in availability of speech-language services across the province. The Working Group's final report (Government of Nova Scotia, 1997) indicated that the Canadian Association of Speech-Language Pathologists and Audiologists (CASLPA) had endorsed SLP to population ratios of 1:1500 for preschool children, 1:2000 for school-age children and youth, 1:25,000 for the general adult population, and 1:10,000 for the geriatric population. No CASLPA document to support these recommendations could be found. In 1997, Nova Scotia was not meeting the recommended ratios in any sector. Certain populations were particularly under-served including the Francophone population, the English as a Second Language population, hearing-impaired students enrolled in special day classes, adolescents, and adults in nursing and special care homes. The Working Group also identified a concern that private and home-schooled students were not able to access services. Lack of awareness and coordination was reported to result in many issues surrounding appropriate referral, transitions between services, and accessibility of services.

The Nova Scotia Working Group made recommendations based on the areas of strength and weakness identified. Due to strong stakeholder support for the existing division of service responsibilities, general recommendations focused on improvements that could be made within the ministerial division of services. These recommendations included the designation of speech-language services as an essential service under the special education funding guidelines of the Education ministry; the development and implementation of methods to identify the needs for speech-language services, establish target ratios, and develop strategies to meet the needs; the development of consistent data collection procedures along with functional measures for evaluating the effectiveness of speech-language services; the development and implementation of prevention programs; the development of regionalized networks of specialized staff and equipment; the establishment of a central coordinating committee of SLPs and stakeholders to facilitate shared use of human resources (with possible establishment of a position within the Department of Education and Culture to coordinate school-based speech-language services across the province); and the provision of inservice training for SLPs to enhance their ability to provide service in areas of specialization (Government of Nova Scotia, 1997). Anecdotal reports at the time of my study suggested that follow-up on these recommendations had been limited (Speech and Hearing Association of Nova Scotia, personal communication, April 8, 2006).

While the Nova Scotia Speech-Language Pathology Working Group identified several important general considerations for the provision of speech-language services, they were not directed to focus on the specific needs of school-age children with communication disorders and the characteristics of the educational system that is the main service delivery context. The notion, however, that speech-language services are tied to education services for school-age children was supported by the Nova Scotia population's strong support for school-based speech-language services. Although the Working Group also used SLP to population ratios to demonstrate a lack of available services, they did not provide any description of how these ratios were established, other than that they were "endorsed by CASLPA." Thus, there is no evidence that the ratios were developed with consideration of the population requiring service, the nature of their needs, and what constitutes appropriate service on the front line. The Nova Scotia report does confirm the continuing attraction of service ratios. It is clear, though, that service ratios cannot be appropriately established without understanding what services are needed and provided on the front line.

Ontario Service Review

The information from Ontario indicated ongoing consideration of the delivery of speech-language services to schoolchildren. In 1994, the Ontario Association of Speech-Language Pathologists and Audiologists (OSLA) approached the Ontario Ministry of Education and Training (MET) with a request for human resources assistance to undertake a study of service delivery to Ontario schoolchildren with communication disorders (Soutar-Hynes, 1996). A partnership was formed and Mary Lou Soutar-Hynes, Education Officer, Language Policy, of the MET Curriculum and Assessment Team, became the project coordinator.

The study's final report notes that responsibility for providing services to Ontario schoolchildren was shared by three provincial ministries (Soutar-Hynes, 1996). The situation is described as originating with Policy/Program Memorandum No. 81 (Government of Ontario, 1984) which included speech-language services as a health support service and described the responsibility for ensuring the provision of health support services as shared among the Ministries of Health, Education, and Community and Social Services. Direct provision of these services at the local level was to be shared by the school boards, the Home Care Program of the Ministry of Health, and agencies operating under the Ministry of Community and Social Services. A distinction was made between speech pathology treatment which was to be administered by SLPs under the Ministry of Health and speech correction and remediation which was to be delivered by speech and language teachers provided by local school boards with consultation from the Ministry of Health (Government of Ontario, 1985).

In 1988, an attempt to clarify Ministry responsibilities was made with the development and release of the *Inter-ministerial Guidelines for the Provision of Speech and Language Service* (Government of Ontario, 1988). The provisions in the Guidelines replaced those set out in the 1984 memorandum. The Guidelines specified that, under the Ministry of Education, school boards would be responsible for the provision of speech and language services when assessment or programming for a communication disorder required the close cooperation with an educational team, needed to be conducted in the educational environment, and/or related to the student's success in school and management by a medical team was not essential (Government of Ontario, 1988). School boards were expected to utilize a spectrum of professional and trained support personnel in a co-operative, interdisciplinary approach. Facilities and Centres of the Ministry of Community and Social Services were described as responsible for the provision of speech-language services when a student was admitted to a facility or centre. Under the Ministry of Health, Local Home Care Programs and Agencies were found to be responsible for the provision of speech-language services when a medical management team was involved requiring co-ordination of other services available within the health setting and when the assessment or programming did not require liaison with an educational team.

Ontario's 1988 Guidelines went further than the general recommendations outlined above. They also made recommendations for specific types of communication disorders that would most likely to fall within each Ministry's responsibility (Government of Ontario, 1988). Under school board facilitation of the development, co-ordination and ongoing monitoring of speech-language services for all students, school boards were to provide assessment and programming for students with language disorders while local Home Care Programs and Agencies of the Ministry of Health were to address most issues related to speech sound production, voice, and fluency, with the exception of those difficulties found to clearly relate to the educational program of the student. Assessment for, prescription of, and orientation to augmentative and alternative methods of communication for non-speaking pupils was to be provided by the Ministries of Health and Community and Social Services while the ongoing development and use of these methods of communication in the educational setting would be the responsibility of school boards, with the support of Home Care Programs, Agencies, Facilities, and Centres of the Ministries of Health and Community and Social Services. In the case of students with multiple or complex needs, development of a process for determining which local service provider would deliver speech-language services and resolving any disputes was recommended. The intent was to avoid duplication of identical services and the provision of speech-language services by more than one SLP.

Although the Guidelines were designed to facilitate more co-operative local decision-making and improve the provision of speech and language services, by 1996 Soutar-Hynes reported that "While they may have been workable in better fiscal times, during the course of this investigation they were more often described as stumbling blocks to effective service delivery, or as a rationale to 'pass the buck' for service delivery from one ministry or sector to another" (p. 26). Due to local autonomy and the lack of a firm mandate for speech-language pathology, some Ontario school boards employed SLPs and some did not. Service delivery was achieved through various combinations of SLPs, speech-language teachers, special education teachers, communication disorders assistants, educational assistants, and/or volunteers. Special service delivery contexts were identified in provincial and demonstration schools with additional special initiatives occurring in northern Ontario and First Nations' education systems. The availability and utilization in schools of SLPs employed under the mandate of the Ministry of Health was described as inconsistent.

More recent information suggests ongoing challenges with sharing of service responsibilities among provincial ministries. In a 2002 review of speech-language service delivery in one local Ontario jurisdiction, Fitzpatrick observed that the responsibility for speech-language services continued to be split among the three Ministries and that the services under the Ministry of Health and Long Term Care were delivered through

Community Care Access Centers which were mandated to provide services to all school-age children regardless of whether they attended public, private, or home schools (Fitzpatrick, 2002a; 2002b). Services provided by individual school boards were described as being funded by the Ministry of Education but without mandate and within the framework of the overall special education funding envelope. Within the jurisdiction included in Fitzpatrick's study, co-ordination of service delivery was a challenging issue. She noted that two different SLPs might see one child in order to provide complete treatment and that there were no standard models for assessment and programming. Although a comprehensive initiative to provide preschool speech and language services had been launched in Ontario in 1997, there were issues related to the transition to school-age services of the between 35-46% of the preschool caseload still requiring speech-language interventions after discharge and with timely identification upon school entry of children who had not received preschool services. Fitzpatrick identified a critical need to create standards to ensure a similar base level of service from all SLPs regardless of employer.

The Ontario SLPs participating in Burnett's 2003 study reported that the government service guidelines "artificially split their treatment mandate, created problems with intra and interdisciplinary collaboration" (p. 180). They also demonstrated how the mandate deprived a select group of student of much needed therapy. These children, who due to the nature of their disabilities, are required to use augmentative communication in order to communicate, were reported to fall "right in the center" of the inter-ministerial mandates and Burnett's SLP participants argued that no ministry was taking appropriate responsibility for serving these students (Burnett, 2003)

In 2003, the Ontario Association of Speech-Language Pathologists and Audiologists (OSLA) conducted a survey of SLPs working for Ontario school boards. The survey found that 70% of responding school boards focused speech-language services only on Kindergarten to Grade 3 students (OSLA, 2003). On average, school SLPs provided service to 167 students annually and the typical mean wait for service was about 5 months with a range from less than one month to 36 months. The OSLA study also revealed that only 21% of school SLPs worked in a service model that included the provision of direct intervention to students. Seventy-two percent of service models focused SLP efforts on assessment, consultation, and the provision of strategies and/or programs for others to carry out. The report documented a significant increase in the percentage of service models utilizing paraprofessionals from 25% in 1998 to 56% in 2003.

Students with language disorders (45%) and students with language and articulation disorders (30%) constituted about 75% of the school SLP caseloads (OSLA, 2003). School SLPs continued to see students with articulation disorders without accompanying language difficulties (21% of caseload) and a small number of students with fluency and/or voice disorders (4% of caseload). According to the Interministerial Guidelines discussed previously, these students could be referred to Community Care Access Centres (CCACs). School boards indicated referring students to CCACs but reported a mean waiting period for CCAC services of 9 months. Procedures for avoiding duplication of services provided by the schools and CCACs were not always in place as evidenced by the fact that 34% of the students referred to CCACs were also being seen by school SLPs.

School SLPs were found to provide one-third of their services to students identified as exceptional according to Ontario education standards and about two-thirds of their service to non-identified students (OSLA, 2003). Twenty-seven percent of students on the average SLP's caseload were identified as exceptional in the high needs categories of "autism spectrum disorders", "developmental delays", and "multiple diagnosis/complex needs" recognized by the Ontario Ministry of Education. These numbers are significant due to additional funding provided to school boards for students within the exceptional and high needs categories.

The results of Fitzpatrick's 2003 study, Burnett's 2003 study and the OSLA 2003 survey figures suggest that nearly 15 years after government initiatives directed at improving services, limitations and insufficiencies in service delivery to school-age children in Ontario remained. These reports also suggested the complexity of service organization within jurisdictions and the prevalence of various organization and government strategies for sorting and classifying students.

Ontario had the most significant history of studying speech-language service delivery and provided an interesting example of an attempt to provide speech-language services to schoolchildren through cross-ministerial collaboration. There was no evidence to suggest, however, that the Ontario cross-ministerial guidelines were based on an understanding of front-line SLP practice. For example, to even attempt to split service responsibilities by diagnosis/area of need is immediately viewed as problematic by those in the field.

The Ontario situation provided a glimpse into the complicated policy overlap that speech-language services for school-age children exist in. Unfortunately, the most recent information coming out of the province continued to suggest that the extensive policy efforts had failed to improve service delivery to school-age children (Ontario Association for Families of Children with Communication Disorders, 2005).

Alberta Service History

Prior to the 1980s, speech-language services in Alberta were provided by schools, health units and some social service agencies with discretionary funds. Concerns arose about a higher demand for services than there were resources and lack of access to services for school-age children in some areas of the province (Alberta Children and Youth Initiative, 2005). An interdepartmental committee with representation from six government ministries including Alberta Education, Hospitals and Medical Care, Community and Occupational Health, Social Services, Solicitor General, and Advanced Education was struck in the mid 1980s. The committee focused on identifying various alternatives for accomplishing the following goals: a) coordinate speech-language services, b) decrease service inequities, c) provide a means of allocating funds specifically to speech-language services and d) allow local communities input into the type of services provided in their area (Alberta Children and Youth Initiative, 2005).

In 1988, the Government of Alberta mandated speech-language services throughout the province. The government ministers of Health and Education announced a $6.9 million funding increase for speech-language services to be delivered through Alberta health units, bringing the total funding for speech-language services to $10.4 million (Alberta Children and Youth Initiative, 2005). Because health units were already well established throughout the province, establishing enhanced services through health units was viewed as a way to address the issues of equity of service and reasonable access for all Albertans (Sutherland, 1992).

Increased services were provided through local public health units to preschool and school-age children (not involved with specialized education or hospital-based services) and to non-institutionalized adults living in the community (Alberta Children and Youth Initiative, 2005). The services were coordinated and funded through Alberta Health, which was responsible for setting program standards and policies. The amount of funding was associated with a SLP to population ratio and resulted in a marked increase in SLP positions in Alberta (Sutherland, 1992). By 1992, Sutherland reported that there were 229 FTE SLP positions compared to approximately 75 FTE in 1988.

Commenting on evolution of the new speech-language services in Alberta health units, Sutherland (1992) noted that preschool speech-language services were becoming increasingly involved in prevention, promotion, and early identification programs in conjunction with other health professionals and that more parenting programs were being offered as part of a "healthy families" initiative. In terms of services for school-age children, Sutherland described a growing need for interactions between health care professionals and educators to ensure what she described as the "total health care of school-age children" (p. 14). Speech-language services were said to be "proving to be quite a pivotal area between health and education" (p. 14).

In 1993, an evaluation of Alberta health unit speech-language services was conducted by an external consultant. The evaluation revealed success in attaining program goals established at the time of the mandate: to coordinate service province-wide, to reduce service inequities throughout the province, to establish a mechanism in each health unit for channeling funds specifically to speech and language services, and to establish an effective mechanism to assist local communities in providing input into the types of services delivered in their area (Seskus & Russell, 1997).

In 1994, restructuring within Alberta Health resulted in the development of community rehabilitation programs throughout the 17 newly established regional health authorities in the province. The responsibility for program administration and funding allocation was transferred to the health regions (Alberta Children and Youth Initiative, 2005). The Community Rehabilitation Program (CRP) was implemented in 1995 and included five rehabilitation disciplines: audiology, occupational therapy, physical therapy, speech-language pathology, and respiratory therapy (Alberta Children and Youth

Initiative, 2005). Each regional CRP became responsible for the program and managing costs for providing community-based rehabilitation services to residents of all ages. Speech-language services for schoolchildren continued to be provided as a unique part of the community-based rehabilitation services. Seskus and Russell (1997) noted that this move increased local decision-making autonomy but resulted in minimal provincial coordination. Shortly after the restructuring, concerns again arose about speech-language services varying widely in structure, scope, and focus across the regions, resulting in inequities (Seskus & Russell, 1997, p. 14).

By the spring of 2004, this issue of inequity and additional concerns about increasing demands for service, shortages of SLPs and support personnel and a lack of coordination of speech-language services for children and youth in Alberta led to the formation of a cross-ministry working committee and cross-sector stakeholder advisory committee (Alberta Children and Youth Initiative, 2005). Formed under the auspices of the Alberta Children and Youth Initiative, these committees undertook a review of speech-language services for children and youth in Alberta. The review was ongoing at the time of my study and has been discussed further in chapters 7 and 8.

Summary

The literature review painted a picture of a young profession, heavily influenced by clinicians trained in the United States and abroad, with service to school-age children a common professional experience but provided under the auspices of a variety of organizations including health, education, or even social service agencies. The SLP workforce appeared plagued by availability issues and job satisfaction and burnout concerns. Significant numbers of SLPs were found to be employed less than full-time.

The picture was not complete. Many unanswered questions about the providers of speech-language services in Canada remained. Very little was known about the backgrounds and day-to-day experiences of Canadian SLPs working with school-age children. The information presented on the role of SLPs serving school-age children demonstrated this dearth of knowledge about Canadian school-age practice and also illustrated the tendency to turn to the American practice literature to fill in the blanks.

While a general consensus supported the presence of large caseloads of primarily elementary school-age children in Canadian school-age practice, little information could be found about the specific characteristics of the children on these caseloads. Speech-language pathologists serving school-age children were concerned that they had too many children on their caseloads to maintain good practices yet their concerns were difficult to substantiate because of the lack of clarity about how *caseload* is defined and managed on the front-line. The extent to which Canadian practitioners were guided by service delivery model concepts from the literature was unknown. Most SLPs serving school-age children have been found to use multiple models and a mix of direct service and collaborative and consultative models but no information existed describing exactly what this mix was and how it played out on the front-line. While it was apparent that some Canadian SLPs serving schoolchildren felt that there were distinct differences between speech-language services provided by Health and those provided by Education, whether the concept of an "education model" of service delivery was specific to the employment situation was unknown. Would the concept of a range of possible alignment with the education practice setting from limited involvement on one end to full immersion on other end make sense to front-line SLPs serving school-age children, even if these SLPs were employed by a health organization? What level of alignment with the education practice setting would actually be observed in their front-line practice? Would low alignment with the education practice setting be synonymous with employment by a health organization? Ultimately, a need to understand if and how front-line SLPs, regardless of their employment situation, attempt to fit their services to local Canadian education contexts was identified.

If little information could be found about how Canadian SLPs serving school-age children conceptualized service delivery in the education setting, even less was identified about the actual tasks they were responsible for, other than generic tasks common to all practice settings or task descriptions from the United States school practice setting, which might or might not be relevant to Canada. I came to the conclusion that increasing understanding of the specific and unique tasks of Canadian SLPs serving school-age children was critical to understanding their current role in the Canadian education and health systems and, subsequently, to maximizing their services' benefits to children and those who care for and educate them.

Caseload versus workload, extending services through the use of support personnel, and outcomes research/evidence-based practice were three "hot" issues in the research literature but again not much was known about if and how Canadian SLPs serving school-age children were affected by these issues. Speech-language services for school-age children and the work experiences of the SLPs who provide them cannot be improved without first knowing if and how these issues are understood and prioritized by the professionals.

Canadian schoolchildren with communication disorders were found to be dependent on what Soutar-Hynes (1996) described as astonishingly fragile systems. Responsibility for providing services varied from province to province and was sometimes split between different ministries within provinces. "Responsibility" often did not extend to mandating particular levels and quality of services. Evidence of struggles in policy-making was significant. The provision of speech-language services to Canadian school-age children is largely the responsibility of complex public systems. The influence of policies made by the employing organizations and government agencies on front-line speech-language service delivery must therefore be investigated and understood. For example, how do the policies of the employing organization and government influence the attempts of front-line SLPs to fit their services to local Canadian educational contexts? When considering how to utilize support personnel in an efficient and effective manner, we must understand where the push for utilization is coming from – is it a front-line SLP concern or an organizational and/or governmental concern? It became obvious that it was not enough to know more about Canadian SLPs serving school-age children and their role because these SLPs are just a small part of much larger service delivery systems. To fully illuminate practice issues, we must broaden our understanding to encompass how their role and practice is influenced by organizational and governmental contexts. Improvements to the equity, efficiency, and effectiveness of speech-language services depend on it.

The lack of information uncovered in this literature review may be attributed, in part, to the speech-language pathology profession's relatively recent emergence on the Canadian scene but can also be attributed to variability in the factors influencing the profession's development across Canada. The profession has been a presence in some provinces for much longer than in others and as a result, is more developed in some provinces than in others. The provinces have also been unevenly influenced by American and foreign trained clinicians and have different ministries - and therefore, different agencies - responsible for service provision. As Martin (2004) has noted, this variability can be considered as a benefit when discussion and debate strengthens individual clinicians and the profession as a whole. However, difficulty in identifying unifying themes to bring together what is a relatively small number of professionals with different professional training backgrounds and sites of practices spread across Canada's vast geographical area was evident and may be hindering the development of a uniquely Canadian professional identity for speech-language pathologists working in Canada.

A clearer picture of what happens in front-line practice and how it is influenced by organizational policies could encourage the development of policies that provide service provision guidelines, assist in establishing the number of professionals required to provide service, and facilitate consistency of practice. The new understandings would, therefore, have promise for reducing SLP job stress and dissatisfaction and might even promote the type of unifying discussion and debate that could move the speech-language pathology profession forward in Canada.

CHAPTER THREE: RESEARCH DESIGN

My study was designed to meet the dual objectives of describing in detail the work of a sample of front-line Canadian SLPs serving school-age children and of explicating the influence of organizational and governmental policies on their practice. The inquiry method and the specifics of the study design were selected to allow me to meet these objectives.

Inquiry Method

Because of my focus on describing and understanding both the work and work systems of front-line professionals from an insider point of view, the philosophies and practices of institutional ethnography informed my stance as a researcher and influenced the research techniques selected.

Researcher Stance

In a seminal work on ethnography, Spradley (1979) stated that the "essential core" of ethnography was its aim to understand another way of life from the native point of view (p. 3). An ethnographer "seeks to learn from people, to be taught by them" (p. 4) about their culture, defined by Spradley as "the acquired knowledge that people use to interpret experience and generate social behavior" (p. 5). The specific type of ethnography that I used, institutional ethnography, upholds these central tenets. It is grounded by taking a standpoint in the everyday world. From that standpoint, the institutional ethnographer traces the actual activities and conditions of the everyday world to the ruling institutional processes and practices which are often invisible to people from a standpoint in their everyday work (Townsend, 1994). Throughout the research, I worked to maintain an ethnographic stance by seeking to understand the work structure of the front-line SLPs, not to prove one thing or another (Janesick, 1991) and to further use the lens of institutional ethnography to consider work broadly and look at how what people did and understood was shaped by organized processes (Campbell & Gregor, 2002).

Research Techniques

Spradley (1979) noted that when doing field work, ethnographers "make cultural inferences from three sources: (1) from what people say; (2) from the way people act; and (3) from the artifacts people use" (p. 8). Institutional ethnographers also use these sources, paying particular attention to how textual media are employed in contemporary work settings to "process" people and manage aspects of their lives. Institutional ethnography proposes that the "processing of people through text" is particularly true for occupations in the human services (Smith, 1999). The "processing of people" is differentiated from organizational dealings with concrete products and includes the organizational strategies for training and managing employees as well as for managing work with clients. The textual media that this processing of people is enabled by and occurs through may include manuals, forms, and reports. According to institutional ethnography, organizational processes exist in the human services to process people as potential clients of the organization and these processes are often put into place through (or mediated by) various organizational texts such as referral/application forms, assessment guidelines, and rules for eligibility.

In my research, I utilized all three of Spradley's information sources by interviewing front-line personnel and other informants relevant to their work lives, by observing front-line personnel in their day-to-day work activities, and by analyzing the policy documents front-line personnel used to guide their work. In keeping with the strategies of institutional ethnography, I paid particular attention to how textual media were employed in the work setting to "process" people and manage aspects of their lives.

Study Design

Selection of the Study System

To be consistent with the purpose of the research it was necessary to select a particular organizational system for study. As noted in the literature review, speech-language services are organized differently across provinces. Alberta was selected as the provincial jurisdiction for this study because of my familiarity with speech-language pathology practice in this province and my enrollment at the University of Alberta. At the time of this study, I was a Canadian and American certified speech-language pathologist and a registered member of the Alberta College of Speech-Language Pathologists and Audiologists (ACSLPA). I also had ten years of experience working with school-age children and four years of experience working in Alberta and had served as the chairperson of the ACSLPA School-Age Services Committee, whose mandate was to liaise with various government agencies on behalf of ACSLPA members and to formulate position statements addressing school practice issues. After completing the field research for my study, I accepted part-time employment with ACSLPA as the Director of Member Services where I was responsible, in part, for providing professional practice assistance to members.

Within Alberta at the time of the study, speech-language services to school-age children were most often provided under the auspices of local health regions. As each health region would have had its own organizational policies, a single region provided a bounded system for study. The health region system for study was strategically selected according to the following criteria: (a) served school-age children in both urban and rural settings, (b) manageable number of SLPs, (c) speech-language pathologists working both with other SLPs and as sole practitioners, and (d) administrative support for the proposed study. Selecting a system that served school-age children in both urban and rural settings was considered important because of increasing concerns within Alberta related to underserving of rural populations. Studying a system that served both urban and rural settings provided the opportunity to describe if and how the SLPs and their work organization defined and attempted to address the challenges of each setting. Having a manageable number of SLPs was an important system criterion because some of the urban health regions in Alberta had so many SLPs that they were organized into numerous sub-offices with layers of administrative support. These large systems would have been difficult to investigate thoroughly given the time and financial constraints of this initial study. Selecting a system where some SLPs worked in offices with other SLPs and some worked alone as sole practitioners was considered important because this variation provided the opportunity to describe any differences in how their roles were constructed or in how their practice was influenced by organizational and governmental policy. Administrative support was an essential criterion for system selection given the objectives of my study.

Administrators within a particular health region expressed an interest in the proposed project and volunteered to facilitate employee participation by allowing interviews and observations of consenting staff to be conducted during work hours. Because the health region's characteristics were also consistent with the other criteria for system selection, it was selected as the study system.

The selected health region served approximately 290,000 residents, covered 60 thousand square kilometers of territory, and employed about 8,000 staff. The largest community in the region was an urban centre with approximately 75,000 residents. Eight SLPs (5.8 full-time equivalent) served school-age children out of a site office in this community which, for the purposes of the study, was known as urban site 1. Also in the region was a smaller rural city with a population of approximately 11,000. Four SLPs (2.3 full-time equivalent) served school-age children out of a site office in that community which, for the purposes of the study, was known as urban site 2. "Rural and small town Alberta" was defined by the Government of Alberta's Rural Development Initiative as those populations living in rural municipalities and small towns and villages under 10,000 people (Government of Alberta, 2004). Using this criterion, there were twelve community health offices in the region located in rural settings. An additional 21 SLPs (11.95 FTE) served school-age children out of those offices. In total, 33 SLPs (20.05 full-time equivalent) were employed to work with school-age children throughout the health region.

Data Collection Procedures

Following the selection of study sites and participants, formal data collection commenced in two stages (see Appendix B). Stage one utilized the front-line SLP(s) serving school-age children at each site as key informants and provided information to meet the first objective of developing a detailed description of the work of front-line SLPs including an examination of their roles as perceived and as practiced. Stage two widened the scope of the investigation to include administrative staff within the health region, teachers and administrative staff within the schools and school districts served, SLPs and administrative staff from a regional consulting team, as well as staff employed by the Alberta education and health ministries and organizational and governmental policy documents influencing front-line SLP practice. This widening forms a critical part of an institutional ethnography and was essential in order to obtain as complete a picture as possible of speech-language services within sites and within the overall system and to meet the second study objective of understanding the influence of organizational and governmental policies on front-line practice.

Throughout the study, I kept a journal record of my subjective impressions, personal biases, and assumptions about the research and if and how they might influence the study. This journal record was used to provide context and background for the analysis and interpretation. Memos were written to outline initial notions about ideas appearing in the data, to describe codes, patterns, and categories arising from the analysis, and to record methodological decisions as recommended in the literature (Ryan & Bernard, 2000).

Stage One Specifics

Stage one data collection was conducted between October and December 2004. As noted previously, front-line SLPs serving school-age children within the region were used as key informants and data collection in this stage provided information to meet the first objective of developing a detailed description of the work of front-line SLPs including their roles as perceived and as practiced

Initial contact with potential participants. In early September 2004 at an information session conducted in conjunction with regional planning meetings, I explained the purpose and design of the study to all front-line SLPs working in the health region, that regional research approval was pending, and my hope that the study would proceed in early October. I described the requirements for participating in the study and how confidentiality would be safeguarded. Those SLPs working with school-age children were advised that I might contact them by email and then telephone in early October to discuss their participation further. Research approval was obtained from the health region in mid-October 2004 and selection of study sites and participants commenced.

Selection of sites and SLP participants. Because of the size of the health region, selection of a subset of study sites and SLP participants from within the study system was required to facilitate deep description of the perceived and practiced SLP roles. Although the study was not designed to compare front-line practice across different work sites within the region, it was necessary to consider certain characteristics of front-line providers and sites when selecting participants to help ensure that a representative picture of front-line practice within the region was obtained.

During an initial discussion of the research project with the regional manager for speech-language pathology and audiology services I obtained a listing of the SLPs employed in the region and their work assignments at different sites for the 2004-2005 school year. Using this list, I first selected those SLPs whose work assignments included at least some work with school-age children and then separated rural and urban sites. Review of this refined listing revealed several different types of work assignments. In both rural and urban sites, some of the SLPs worked only with school-age children while some worked with both preschoolers and school-age children. It did appear that SLPs working in the rural area were more likely to work with both age groups. This was likely due to another difference in work assignments – five of the rural SLPs were sole practitioners, meaning that each was the only SLP designated to a particular community health office, in contrast to offices staffed by more than one SLP (designated as "team" offices for the purposes of the study). All of the sole practitioners worked with both preschool and school-age children, a fact which was likely a result of low populations in and around these sub-offices.

Table 1 illustrates the different settings and apparent work assignments for SLPs serving school-age children in the health region as based on the information originally provided by the region:

Table 1

Settings and Work Assignments of SLPs serving School-age Children in the Study Health Region

SLPs Serving School-age	Schools and Preschool		Schools Only	Total
	Team	Sole	Team	
Rural	8	5	8	21
Urban Site 1	3		5	8
Urban Site 2	2		2	4
Total	13	5	15	33

In selecting the stage one participants, the goal was to balance the number of participants across each of the different site and work assignment sub-types. To that end, two SLPs were selected to represent each of the seven categories represented in Table 1 – rural/schools and preschool/team, rural/schools and preschool/sole, rural/schools only/team, urban site 1/schools and preschool/team, urban site 1/schools only/ team, urban site 2/schools and preschool/team, and urban site 2/schools only/team. With the exception of the urban site 2 categories which provided only two potential respondents per category, two participants from each category were randomly selected to be invited to participate in the study.

Each selected SLP was approached via email and follow-up phone call in October 2004. Formal study information letters and consent forms were provided as email attachments for their preliminary review. Reselection of potential participants was required for three categories (rural/schools and preschool/team, rural/schools only/team, and urban site 1/schools only/team). In total four of the originally selected participants declined. In three cases (one from each of the previously mentioned categories), the originally selected participants declined because they were new graduates focused on mastering their first work positions. One other potential participant from the rural/schools and preschool/team category declined because of lack of time due to a prior commitment to supervise a practicum for a student from an assistant training program. In all four cases, replacement participants were randomly selected from the remaining pools and contacted by email and phone in the same manner as the originally selected participants. All agreed to participate.

The selection process provided 14 primary participants, a number which was considered appropriate given the limited scope of the study, the goal of deep description, and my intent to follow-up with theoretical sampling as necessary. Ultimately, theoretical sampling became necessary in only one case. Background information about a particular rural site was obtained from one additional SLP who participated in a single interview.

Data collection strategies. To inform the questions and methods used in stage one of the study, I conducted informal trials of interview questions and observation strategies in August 2004 with three SLPs working with school-age children in other regions of Alberta. Feedback from these experienced professionals was used to refine the interview questions and observation strategies.

Initial interviews. As the first data collection step in stage one I conducted a one-hour, semistructured, audio-recorded interview with each participating SLP. The SLP information letter and consent form were reviewed with all SLP participants at the time of their first interviews (see Appendix C). Informed consent was obtained from each of the participants. An interview guide was used in the initial interview, during which time the participants were asked about their backgrounds, perceptions of the ideal role for SLPs working with school-age children, role in the health region, and for a detailed description of their different work tasks (see Appendix D).

At the conclusion of the initial interview, each participant and I worked together to develop a possible schedule allowing me to observe the SLP engaged in different tasks that were ongoing at the time of the field research. To maintain consistency, all of the initial interviews were completed prior to commencing the observation phase.

Observations. After reviewing the schedules of potential observation times developed in the initial interview, I identified different tasks to be observed and the potential for observing them and approached each SLP with a tentative schedule for their approval. Timing of the observations was opportunistic according to the schedule of the SLPs. In some cases, SLPs structured their work days so that they conducted many different types of tasks in one day and in these cases, I observed an entire work day. Other SLPs were engaged in the same task (i.e., assessments) repetitively during a day and in these cases, I observed only part of one day and scheduled additional observations on other days in order to observe different tasks. Ultimately, I spent 15 days observing SLPs at the various study sites in order to observe the different tasks identified during the initial interviews to the point of saturation of the data related to the study objectives. Saturation of the data occurs in institutional ethnography when sufficient data had been collected to record how everyday practice actually worked within the institutional framework. Data collection in my study continued until no new information was obtained when the same tasks were observed repeatedly.

The observations focused on the purpose of the study – to describe front-line practice and to understand the influence of organizational and governmental policy on front-line practice – not on evaluating practice or activities of individual practitioners. I kept written field notes describing the settings and interactions observed. In keeping with institutional ethnography, the data recorded SLPs' real actions and talk as well as the people involved, locations, time frame, equipments and supplies which created the material conditions of everyday practice. Guiding questions for me during this observation phase included the following, moving from general to specific queries: What activities are the front-line SLPs involved in? What purposes do these activities serve? How do these activities relate to other types of work in their surroundings? Are the activities client-centered or organization-centered? Who determines the activities? Are the activities SLP-directed or policy-directed? When activities are organization-centered and/or policy-directed, how is the organization and/or policy influence achieved? Are there policy documents that guide the activities of SLPs and what are these policy documents?

I did not participate in the activities observed but was a privileged observer in that I was privy to basic clinical information about the students involved in therapy sessions and had access to their client files. When I observed the SLPs' practice I also reviewed randomly selected client files to gain additional information on how organizational and/or governmental policies were reflected in the paperwork process of the front-line practice setting.

Observations were ultimately conducted with 13 of the 14 participating SLPs. In one SLP's case, direct observation of practice became impractical due to a combination of poor road conditions and inaccessibility of the SLP's work sites in rural Alberta. In this case, we engaged in additional discussion of the SLP's practice and I reviewed a selection of client files.

Second interviews. After the observation phase was completed and the initial interview data and field notes analyzed, a second, one-hour, semistructured, audio-recorded interview was conducted with each participating SLP in December 2004. These interviews focused on clarifying information obtained from the first interviews and from the observations. In the first part of the interview, specific questions were asked of each SLP (see Appendix D) but in the second part, each SLP was presented with sets of cards I had made to portray the tasks and steps involved in specific key work activities as identified during the initial interviews and subsequent observations. This technique has a long history in qualitative methods (Spradley, 1979). As the sets of cards were reviewed with each SLP, he or she was asked to agree or disagree that each task was indeed something he or she did and was also asked to comment more specifically on the content of each card and the organization of the card sets. The ensuing discussions provided an opportunity for participant check of accuracy and completeness; that is, feedback was obtained from participants to ensure that I had documented their point of view correctly and that my preliminary interpretations were appropriate. Because the stage one field research was conducted at a particular time during the school year, I also used the second interviews to request additional information and clarification of if and how the tasks undertaken by the front-line SLPs would change over the course of the school year.

Theoretical sampling. Data analysis and preliminary interpretation revealed a thin area in my understanding of the historical circumstances and current organization of a particular rural office. Because the participating SLP from that office was new to the region and to the office and therefore unable to completely facilitate my understanding, I conducted a single, one-hour audio-recorded interview with the only other SLP employed at that site in order to obtain additional information. Prior to the interview, the stage two information letter and consent form was reviewed and informed consent received (see Appendix C).

Informal interviews. During my time on-site, several opportunities to conduct informal interviews or conversations with school district employees arose. I interviewed two teachers, four school administrators, and one special education coordinator during the on-site phase. I informed these individuals about the purpose of the study and each received the stage one informal interview information letter and consent form (see Appendix C). Informed consent was obtained from each of these secondary participants. Our conversations focused on their general experiences with speech-language services and their views on the structure of the services, not on specific cases, and took no longer than 30 minutes. The content of the conversations was recorded in my field notes.

Stage Two Specifics

Stage two data collection was conducted between December 2004 and October 2005. In this stage the main focus was on explicating how local practice was influenced by the relevant texts and textual practices (Campbell & Gregor, 2002). As used by institutional ethnographers, the word *text* refers to a wide variety of documentary media which create an account of experience and *textual practices* are those which create objectified knowledge by textual representation of selected facts about actual experiences (Smith, 1990). In my study, the relevant texts were largely organizational and governmental policies and procedures. My examination of textual practices therefore related to how the objectified knowledge of the identified policies and procedures coordinated and controlled the work processes and decision-making of front-line SLPs. In addition to my review of relevant texts, I also conducted formal interviews. These interviews provided insight not only into the influence of organizational and governmental policies and practices on front-line practice but also into the influence of the structure and characteristics of these institutions and their management on said practice.

Review of relevant texts. I identified the documents relevant for review during my time on-site in stage one and during the subsequent contextual analysis. These documents included local health region policies on speech-language services and numerous documents from Alberta Education and Alberta Health and Wellness. Local health region policy documents were provided to me by the SLP manager while government documents were available to the public through the ministry websites.

Formal interviews. Individuals were selected for interviews according to my presumption of their ability to answer specific questions raised in the first stage of data collection, to clarify the accuracy of my picture of speech-language services within sites and the overall system, and to increase my understanding of the influence of organizational and governmental policies on front-line practice. This presumption was based on my preliminary knowledge of their professional and organizational roles. For example, in the first stage of data collection it became apparent that certain health region policies and practices influenced front-line SLP work so I conducted interviews with both the SLP pediatric team leader and the SLP manager. I also conducted interviews with the coordinator and SLP employees of a regional consulting service active in the health region studied and with representatives of the government ministries, Alberta Health and Wellness and Alberta Education. The interviewee from Alberta Health was that ministry's representative to a provincial review of speech-language services as were two of the four interviewees from Alberta Education. The other two Alberta Education interviews focused on early childhood services (2.5 to 6 years) and regional consulting services respectively. In all cases, I explained the purpose and design of the study to potential interviewees and provided them with the stage two information letter and consent form (see Appendix B). Informed consent was obtained from all participants.

Data Analysis and Interpretation

Preliminary analysis and interpretation of data occurred during the collection process and informed that process for both stages of the study. Because of the study timeline and the nature of the information collected, I worked with the stage one data from the primary SLP participants first and then with the data from the stage one informal interviews with school district employees and the stage two formal interviews with the SLP pediatric team leader and SLP manager, coordinator and SLP employees of a regional consulting service, and representatives of Alberta Health and Wellness and Alberta Education. While the same techniques were used to analyze and interpret the data from these two sets, the specifics of the analysis and interpretation differed because of differences in the data and its desired use. As a result, I have commented on the data analysis and interpretation on each data set separately.

Data Set One: Front-Line SLPs

Thick description of the perceived ideal and currently practiced work roles of participating SLPs was developed by reviewing interview transcripts and field notes and through theoretical insights developed from these materials (Morse & Richards, 2002). Content analyses were conducted on the data collected in field notes and interview transcripts. With the stage one data, I focused on sorting by work processes. As Townsend (1994) noted, sorting data by actual work processes, rather than interpretive themes such as “choice”, is conceptually consistent with institutional ethnography. Analytic coding was used to obtain patterns and categories (LeCompte & Schensul, 1999) and proceeded according to a selective or highlight approach. Consistent with qualitative research and institutional ethnography, the language used by study participants informed the data codes. I began by highlighting statements or phrases (elements) from the interview transcripts and field notes that seemed relevant or essential to meeting the objectives of the study. These elements were then sorted into preliminary categories. The data within this first set seemed to naturally form three relevant clusters –

that relating to the perceived ideal role of the SLPs, that relating to their current role, and that relating to policy and practice issues arising from the organizational and governmental context of their work. I worked with the data in the first two clusters first, retaining the data on policy and practice issues for further consideration with the second data set.

Once the data in each cluster were categorized, I created subcategories as necessary to clarify the data. I drew tree diagrams to illustrate the emerging relationships between categories and subcategories. Categories selected as the most relevant to the objectives of the study were pursued and analyzed in the most detail. Analysis was an iterative process during which I cycled through conducting interviews and observations, reading and rereading the interview transcripts and field notes, working and reworking the categories and subcategories, and redrawing and revising the tree diagrams. Information from different sources and from the same sources obtained through different methods was considered both separately and together. Throughout the analysis of the data my reasoning was inductive and attention was given to identifying negative or disconfirming cases (LeCompte & Schensul, 1999). For my study, negative or disconfirming cases would have been instances in which the veracity of data came into question. Because I was interested in obtaining a range of perspectives or individual truths about my subject, variance between participants in their responses was anticipated.

During the second interviews with participating SLPs, I used targeted questioning and the presentation of card sets with some of the categories, subcategories, and elements relating to their perceived ideal and currently practiced roles organized to approximate my emerging tree diagrams. These strategies allowed me to check my preliminary analyses and interpretations. Ultimately, all categories and subcategories were judged on both internal and external homogeneity. To ensure internal homogeneity I ensured that all of the data reflected the category/subcategory and that the category/subcategory made sense. For external homogeneity I ensured the relationships between the categories and subcategories were distinct and separate. After I was satisfied that the categories and subcategories completely represented the data, I returned to the "big picture" level and reconsidered how the categories and data clusters were related and the common themes that could be identified across the data set.

During the process of analyzing and interpreting the data from each cluster, specific issues arose. These issues have been described in detail in the following sections.

Perceived ideal role data cluster. The question about ideal role appeared straightforward when I first considered it and even after it was used in informal trials with three SLPs working with school-age children in other regions of Alberta. However, as I collected and analyzed the data obtained from the participating SLPs, I began to notice differences in how they approached answering the question. While they all seemed to have no difficulty providing immediate and often extensive comment, a split emerged between those SLPs who provided specific ideas about the work processes or tasks making up the ideal role and/or how to best accomplish those tasks and those who seemed to deal with the question on a broader, philosophical level and whose answers tended to encompass practice (work) rather than enumerate specific elements. Initially concerned about developing a cohesive vision of the ideal for school-age practice, I attempted to have the SLP participants review and independently verify each other's comments during their second interviews. During this process, the split between the "detail" people and the "big picture" people became even more evident. Those who had initially responded to the question with specifics did not identify with the comments of those who had responded with more philosophical comments and vice versa. A typical comment was similar to "Well that's true, of course, but I don't really feel that's part of *my* ideal."

"Ideal" presented itself then as a very personal concept. In subsequent coding and categorization of my interview data it became evident that I was dealing with a collection of different viewpoints on the ideal role of SLPs working with school-age children. All of the viewpoints were relevant to understanding what front-line SLPs hope to achieve in their practice but none applied to all of the participating SLPs all of the time or perhaps more accurately, none would be ranked similarly in importance by all participating SLPs. During my analysis and interpretation of the data I first developed categories of data, then subcategories, and then after resolving any inconsistencies within categories and any overlap between categories I separated the categories of data according to the perspective reflected.

Currently practiced role data cluster. I first analyzed the data in this cluster by identifiable work processes. The term *work processes* was first conceptualized as the specific tasks and subtasks carried out by the front-line SLPs. For example, *Processing Referrals* was identifiable as a task. Subtasks within that task included but were not limited to *Interacting with Referral Source*, *Observing Potential Referrals*, and *Providing Paperwork*. However, it is consistent with institutional ethnography to also include within work processes how workers talk about or conceptualize their work. During the analysis, I identified some work processes that were more ways of thinking about their work than actual practice tasks. This data split was similar to how some of the data in the perceived ideal role cluster provided specific ideas about the work processes or tasks making up the ideal role and other data seemed to encompass SLP work. I ultimately clustered the specific work tasks under *Activities* and the participants' ways of thinking about their work under *Understandings*. Identified activities and understandings were then grouped into three categories based on the apparent orientation of the role activity: client-focused, service-focused, and environment-focused. Two tasks, *Scheduling the Service* and *Working with Assistants* were found to have both client-focused and service-focused components. Because of this dual focus and the pervasiveness of these activities in practice, they were selected for more detailed analysis of the subtasks.

After the first analysis was completed, the data support for the client-focused and service-focused categories was much stronger than for the environment-focused category. In my second interview with each participant, I validated the category and task analysis by requesting feedback on card sets I had prepared to represent the organization of tasks and subtasks. In addition to verification of the task and sub-task activities, I asked participating SLPs to review the terms used to label the tasks and sub-tasks and the categorizations. I also questioned participants to clarify whether an environment focus was in fact a part of their currently practiced role.

Participants affirmed that the *Increasing Community Awareness* and *Educating* tasks grouped in the environment-focused category were accurate but did not identify as strongly with an environment focus to their activities. This result made sense in light of the fact that I had been unable to ascertain any data representing participant understandings associated with the activities I had grouped as environment-focused. In discussions with the participating SLPs, it became evident that they were reluctant to accept even perceived responsibility for environment-focused activities as they were already overburdened by the client-focused and service-focused activities. Many participants expressed that, at the time of my study, an environment focus to their activities would be more ideal than actual.

Participating SLPs expressed greater discomfort with the environment-focused task I had identified as *Advocating*. In our discussions, it became clear that while they may have been doing activities that could be considered advocating or "pleading in favor of; defending a proposal" (Merriam-Webster, 2001), many were not comfortable with the label. Because participants did not entirely identify with the categorization of environment-focused, I decided to consider the environment-focused category a "shadow" category and left advocacy in its task list with the idea of exploring these concepts further in future research.

Data Set Two: Organizational and Governmental Context

The second data set was comprised of field notes and transcripts from the informal interviews conducted in stage one and the formal interviews conducted in stage two as well as local health region, Alberta Education, and Alberta Health and Wellness documents. In keeping with institutional ethnography, analyses focused particularly on textual practices which coordinated and controlled the work processes of front-line SLPs. I also considered the influence of the structure and characteristics of the relevant institutions and their management on front-line practice.

Content analyses were conducted on the data collected in field notes and interview transcripts. Analytic coding was used to obtain patterns and categories (LeCompte & Schensul, 1999) and proceeded according to a selective or highlight approach. I began by highlighting statements or phrases (elements) from the interview transcripts and field notes that seemed relevant or essential to meeting the objective of explicating how local practice was influenced by organizational and governmental policies. This consideration was based on the conceptualization of local practice I had obtained during my time on-site in stage one and the subsequent analysis of that data. The policy documents were considered in terms of content but also in terms of intent when interviews with the authors of the policy were possible. They served as touchstones providing the "official picture" of service delivery and as the basis of a comparative analysis of policy versus practice.

Rigor

Specific verification strategies were employed throughout the conduct of the study to incrementally contribute to the rigor of the study. Methodological coherence or the congruence between the research objectives and the components of the methods was monitored throughout the study (Morse, Barrett, Mayan, Olson, & Spiers, 2002). Participants were selected in a manner appropriate to the purpose of the study (Morse & Richards, 2002). For this study, strategic selection of participants from within predetermined practice categories and theoretical sampling in which participants were sought according to emerging theoretical schemes were most appropriate. Collecting and analyzing data concurrently developed an iterative interaction between data and analysis and allowed me to determine how well the data collection strategies were working and to adjust the pacing of the project (Morse & Richard, 2002). Throughout the research, I focused on "thinking theoretically" (Morse et al., 2002), adopting micro-macro perspectives while constantly checking and rechecking data to build a solid foundation.

I also considered the "trustworthiness" and "authenticity" of the study (Guba & Lincoln, 1989). The analysis of an institutional ethnography has been described as having an "inherent truth" in that it is based on an empirical account of the actual activities of real people in real practice situations (Townsend, 1994). I collected multiple, overlapping data for cross-checking analysis in observations, interviews and documentation. Participant checks were conducted throughout the study and the dissertation supervisor reviewed samples of data and interpretation. The accuracy of the information provided by informants was assessed by considering the consistency of the information provided and the written documentation within client files. When interviewing informants, I also included questions and card review activities that revisited topics and issues in order to check the accuracy and completeness of information provided and prevent distortion. During the analysis and interpretation phase, I alternated coding, re-reading, and thinking to ensure that my argument fully accounted for the data.

Throughout the study, I endeavored to be consistent and complete in process and action. The supervisory committee assisted me with these strategies and was available to discuss and review challenges arising in data collection and analysis.

Assumptions and Limitations

The institutional ethnography research methods used in this study were assumed to be the best way to obtain a complete picture of a practice setting. Looking at the work world of the SLPs in different ways through interviews, observations, and document review reduced the chance of misinterpreting the settings. Grounding the study in observation in naturalistic settings strengthened validity and reduced the chance that phenomena were overlooked. It was assumed that thick description and analysis within one practice setting and one organization would provide information useful in other practice settings and organizations. There was support for making this assumption within the general qualitative literature and within the specific ethnographic literature (Janesick, 1991; Spradley, 1979). In the context of the objectives of the proposed study, this assumption was appropriate as it would not be possible to fully explicate the influence on practice of organizational and governmental policy issues without focusing on one particular practice setting and organization. In addition, Smith (1987) has noted that institutional ethnographies reveal how institutional processes and practices are ideological "generalizers of actual local experience" (p. 154). This concept is a powerful one for helping front-line SLPs understand the facilitators and barriers of their practice regardless of their setting and for sensitizing administrators, policy makers, researchers, and educators to contextual influences on front-line practice. This type of qualitative research has also been shown to lead to new insights and hypotheses. This advantage was critical as there was little research on SLP practice with school-age children in Canada at the time of the study.

A study of this kind could have been limited by the unwillingness of front-line SLPs to participate, however my participation as a researcher was warmly received by those on the front-line. Limitations may be perceived in the representativeness of the health region and of the SLPs working with school-age children in that region. This limitation was reduced by structuring the objectives of the study to focus on practice within the health region, detailed description, and naturalistic generalization. Selecting the initial group of participating SLPs strategically to represent certain elements of practice provided a stronger foundation for claiming that the resulting data was representative of practice in the region. While the intent of the study was not for statistically supported generalization to practice within health regions across Alberta, the information collected about the professional training and years of experience of participating SLPs and subsequent comparison to provincial data indicated that the study participants were fairly typical of SLPs in Alberta.

Observation records are often long and difficult to quantify and interpret. Because it is impossible to write down everything, observers must make on-the-spot decisions about what to write down and what to omit. While I did not have extensive formal training in observation for research purposes, it was thought that this limitation was overcome by the knowledge gained in my experience as a front-line SLP, my previous research experiences, and the support and review provided by my supervisory committee. In any study using observation, there is always a concern that participants will behave differently in the presence of the researcher. In this study, I was able to compare stage one data obtained from interview, observations, and file reviews which allowed me to discuss any conflicting information with participating SLPs. As informants were relied on during data collection, accuracy and completeness checks on the information collected and its interpretation were critical and were embedded throughout the study. I was also cautious about overinterpreting the data given that I could only know what participants were willing to divulge. Although formal ethnographic studies traditionally utilize a longer time spent observing in the field, this study's institutional ethnography focus, specific objectives and my prior experience made a more limited timeframe more appropriate.

Because I am a registered and certified SLP, the potential for role conflict existed. This potential was reduced by my careful consideration of my views and opinions about practice as recorded in the journal kept throughout the study and by my resignation from committee chairperson for the provincial professional college for the duration of the field research.

Ethical Considerations

This proposal received ethics approval from the University of Alberta Faculties of Education and Extension Research Ethics Board and research approval from the health region where the study took place. The main ethical considerations were informed consent and confidentiality. As previously described, I reviewed the purpose and procedures of the study with all potential participants and each received copies of the information letter and consent form. Signed consent forms and a copy of the information letter were returned by participants to me in person. The written consent guaranteed confidentiality. I have not and will not release the names of participants to anyone, including their employers. This degree of confidentiality was necessary to ensure that participants were truly free to participate and that no ramifications are possible for non-participation. Once I received the signed consent forms, each participant was assigned a letter code and number. Multiple letter codes were used to identify the type of participants (e.g., S for SLP, T for teacher, A for administrator), type of setting (i.e., U1 for urban site 1, U2 for urban site 2, R for rural) and, for SLPs, type of practice (i.e., SO for school service only, SP for school and preschool service, S for sole practitioner, T for team). Each participant's letter code and number were also used to identify all field notes and interview transcripts. Throughout this document participant quotes have been identified by participant code, source, and line number. For example, "S10-U1-SO-T Int 1 LN 332-348" is code for lines 332-348 from the transcript of the first interview with SLP participant number 10, from urban site 1 who was engaged in serving school-age children only from an office with a team of SLPs. I have not and will not divulge the health region where the study took place nor the specific community health or school sites where interviews and observations occured to anyone outside the health region other than to my supervisory committee.

CHAPTER FOUR: A PRELIMINARY LOOK AT THE FRONT-LINE PARTICIPANTS AND THEIR WORK WORLD

In this chapter, I have presented factual information about the front-line SLPs who participated in the study and their work world. This information was uncovered during interviews and observations with front-line SLPs in stage one and during interviews and document review conducted in stage two of the study. Characteristics of the front-line participants have been presented first, followed by information on their work world. This information will provide the reader with the background necessary to support my subsequent interpretation of the research data.

Who They Were: The Participants

Fourteen front-line SLPs participated in the study, two from each of the following categories - rural/schools and preschool/team, rural/schools and preschool/sole, rural/schools only/team, urban site 1/schools and preschool/team, urban site 1/schools only/ team, urban site 2/schools and preschool/team, and urban site 2/schools only/team. Because of the small number of potential participants in each category, participants were not profiled by category as they would be too readily identified by others in the study region. In Appendix E, however, demographic information is provided to describe the participants by professional training site, highest degree earned, years of work experience, type of work experience, FTE worked, and number of schools served. Where possible the same information has been provided for SLPs throughout Alberta. This comparative information was obtained from the Alberta College of Speech-Language Pathologists and Audiologists (ACSLPA). All SLPs working in Alberta must be members of ACSLPA, the regulatory body.

In summary, slightly more than half of the participants had received their professional training in Alberta (57%) and the majority of the study participants had earned master's degrees in speech-language pathology (86%). This was consistent with the overall profile of SLPs in Alberta provided by ACSLPA. Seventy-eight percent of the participants had more than five years of experience in the field. All but one had worked with other populations in addition to school-age children. Part-time work was common among both participants and the overall set of ACSLPA members. However, slightly more of the participants worked full-time (64% compared to 58% throughout the province.) Despite the fact that only 64% of participants worked full-time, 79% served students at more than three schools. ACSLPA could not provide information about the years of work experience, type of work experience, or number of schools served by its members.

The 14 participants were part of a cadre of 33 SLPs (20.05 full-time equivalent) employed to work with school-age children in the Alberta health region selected for study. They worked out of community health offices. Some saw preschool children in addition to their school caseloads. The needs of most adult clients in the region were addressed by other SLPs in acute care or continuing care settings. Community health SLPs, particularly in the rural areas, had the option of taking adult clients but in practice did not, with the exception of one SLP who specialized in fluency.

Where They Worked: Site Offices and Schools

The work days of participants were typically spent either in their site offices or, more commonly, out serving children in schools. These locations thus formed the immediate context of their work lives.

Site Offices

There were significant differences across sites in the office space available to front-line SLPs. Some of the office space available in rural sites with limited staffing was generous and private. The vast majority of office space in urban sites was shared and although space and access to office technology was at a premium, the front-line SLPs at these sites reported that their situation was manageable. They did have some difficulty obtaining space for private meetings such as conferences with SLP assistants or with students on practicum placements. At two of the sites in larger rural centers, however, lack of appropriate office space was reported to constrain practice. In one of these sites, three SLPs and one SLP assistant shared the same office space and a single computer. In the other, two SLPs and two SLP assistants shared a single computer housed in a group of small offices tucked away in the basement of a leased building. Front-line SLPs involved in these two offices reported that their ability to complete documentation and make private phone calls to schools and parents was hindered by the physical space available to them. At the time of the study, only one of these sites was scheduled to have its physical space limitations addressed under the health region infrastructure plan.

School Sites

Because of their practice serving school-age children, participants spent most of their work time in schools. As the characteristics of the school assignments of the participants would identify them to fellow employees, school assignments for all health region SLPs and school jurisdiction profiles have been summarized in Appendix F. In summary, the eight SLPs working out of the urban site 1 office were responsible for serving school-age children from one Catholic school jurisdiction, four public school jurisdictions, as well as four private Christian schools and one private special needs school. Six of the eight SLPs served schools from more than one jurisdiction. The schools served were located within the boundaries of urban site 1 and in the outlying rural areas. The SLPs working out of the urban site 1 office were assisted in serving the schools within the largest public jurisdiction by two SLPs historically employed by that jurisdiction. The funding for these positions had come from the health region since 1989 when responsibility for speech-language pathology services in the province was allocated to the ministry of health. Prior to a 1999 government initiative to improve student health services, these two SLPs had served all of the schools in this jurisdiction. After the health region received additional funds through the special initiative, additional SLPs were hired by the health region to serve some of the schools.

The four SLPs working out of the urban site 2 office were an anomaly in that they were responsible only for serving school-age children from one public school jurisdiction (albeit a large one). The schools served were located within the boundaries of urban site 2 and in the outlying rural areas. A contract worker (.4 FTE) also served two schools, including one in a Catholic school jurisdiction.

The twenty-one SLPs working out of rural site offices were responsible for serving school-age children from seven public school jurisdictions, four Catholic school jurisdictions, as well as six private Christian schools and one private special needs school. Fourteen of the twenty-one SLPs served schools from more than one jurisdiction.

The fact that the majority of health region SLPs were assigned schools from more than one jurisdiction hinted at, but did not completely reflect, the complexity of their work situations. Even when the schools they were responsible for were within the same jurisdiction, a trend toward school-based management practices meant that the priorities and resources of each individual school could be quite different. Some of the rural and private schools had very low student populations, with correspondingly miniscule numbers of students in need of speech-language services. Other private schools were dedicated to special needs students and as a result, required consultation for their entire student populations. These factors were added to the typical differences resulting from the socioeconomic status and other population characteristics in schools' catchment areas. In addition to differences in administration and student populations, front-line SLPs faced dramatic differences in the physical spaces available to them at different schools. In some schools, participants shared a dedicated and appropriate office space with their assistants. Often, participants were able to book office space that was shared with other personnel. Unfortunately this office space was sometimes inappropriately small and/or noisy and/or lacking in privacy and unavailable when needed. Occasionally, participants were required to move from space to space within a school within the course of a day's visit due to space constraints.

Who They Worked For: The Health Region

Most of the area covered by the health region at the time of the study had been part of it since a first round of health region reorganization in 1994. A second round of reorganization in 2003 had added parts of two other health regions to the study region including urban site 2 and surrounding areas and five of the twelve rural site offices.

Administrative Team

The study region employed a regional manager for speech-language pathology and audiology services in addition to regional managers for physical therapy, occupational therapy, recreation therapy, and pediatric rehabilitation services. All of the regional rehabilitation managers met every two weeks to plan and coordinate services. They reported to the director of regional rehabilitation services who in turn reported to the vice president of community and continuing care services. The vice president of community and continuing care services reported to the senior vice president and chief operating officer – health services. This senior vice president reported directly to the president/chief executive officer of the health region who in turn reported to the regional health authority board.

The SLP regional manager was responsible for community, ambulatory, inpatient, and continuing care SLP services, audiology, and dyphagia services. This individual was in charge of the day to day operations at all sites, working with Human Resources to recruit new personnel, and managing the budgets. The manager was assisted by two team leaders – one for adult services and one for pediatric services. The SLPs serving children were organized into three geographical groups – south, central, and north. The north group reported directly to the SLP regional manager while the south and central groups were supposed to report directly to the pediatric team leader. At the time of the study, however, the pediatric team leader had been seconded to a team working on a new statistics and reporting software program for the region. The team leader continued to orient new staff members and assist with organizing staff meetings but the SLP regional manager had resumed handling the remaining staff supervision duties. When interviewed, the manager noted that centralization of the rehabilitation service and of speech-language services within the health region was quite different from most other Alberta health regions where services were often separated by age groups (e.g., preschool, school, and adult) and/or service sites (e.g., community versus continuing care).

Planning and coordinating services with community partners was a significant responsibility of the SLP regional manager. At the time of the study, the regional manager represented the health region's SLP services on three Student Health Initiative Partnerships (SHIPs), two of which were in the process of amalgamating into one. Regional Student Health Initiative Partnerships were developed throughout Alberta beginning in 1999 (Alberta Children and Youth Initiative, February 2004). Supported by the Government of Alberta Children and Youth Initiative's Student Health Initiative funding, partnerships consisted of the school authorities, the regional health authority, including mental health, and the child and family services authority from geographical regions of Alberta. The partnerships develop joint service plans to identify how they will respond to the special health needs of students within their regions. Speech-language therapy has been one of the top two service priorities for SHIPs since their inception (Student Health Initiative, June 2005). All three SHIPs within the study region were funding SLP and/or assistant positions at the time of the study. For two of the SHIPs, when positions were supported, the funds came to the health region and the subsequent

FTE was pooled with the FTE already supported by the health region. The SLP regional manager reported to the SHIPs about the use of the funds.

It is important to note that the regional manager was a registered speech-language pathologist who had worked as a front-line clinician within the health region for over ten years prior to moving into an administrative role. The manager had therefore experienced as a front-line clinician various historical shifts in government policy and funding of speech-language services as well as changes in the organization of health services as a whole including regionalization of services and the first wave of changes to health region boundaries. Part of the manager's front-line experience included serving children in rural schools. Interestingly, when interviewed the manager indicated that SLP assistants had been employed in the region since 1989, well before they were common in the province.

Working Groups

The north, south, and central SLP working groups met approximately four times each school year. Each group had a chairperson and a volunteer took minutes at each meeting. In the spring and fall of each year, all staff came together for several days of program planning. During these planning days, some of the emphasis was on program review and professional development sharing. Primarily, however, the SLPs worked with their administrative team to respond to various program needs by defining projects. Whenever possible, projects were designed to also relate to goals in the overall regional plan. Sometimes projects were undertaken just to respond to tasks assigned during regional planning. Each working group then worked over the following year to complete one or two projects and provide feedback to everyone. For example, a project to determine what the program's policy should be regarding referrals for children with English as a second language was underway at the time of the study. The groups were self-governed and set their own goals in order to achieve the desired end. They consulted with the regional manager as their projects unfolded.

CHAPTER FIVE: FINDINGS AND DISCUSSION - PERCEIVED IDEAL ROLE

"I always get asked, 'What's your dream for this child?" (S3 R-SP-S Int 1 LN 90)

In this chapter, I discuss participating SLPs' perceptions of their ideal role in working with school-age children or, essentially, their dreams for their practice. My interpretation of the data from their first interviews is demonstrated in Figure 1 on the following page. The two circles represent the two participant perspectives identified in the data. Some participants appeared to have primarily an overarching or philosophical perspective on the ideal role while others took a more specific or task-oriented perspective. No response differences based on participants' identification in rural versus urban or schools only versus schools and preschool practice were identified. The text boxes in the outer circle portray how data related to an overarching or philosophical notion of practice clustered into five categories and, for participants with that predominant perspective, became a backdrop for the specific tasks of practice. Other participants provided data reflecting a predominantly task-oriented perspective. The more specific, task-oriented data clustered into the three categories listed in the inner circle.

In the following sections I address each perspective separately, beginning with the more specific perspective on practice and moving to the more global. Each category of data, subcategories, and relationships between categories and subcategories will also be described. I discuss whether and how the ideas expressed by the participants have received support in the practice literature. Finally, a summary of the perceived ideal role of front-line SLPs will be provided.

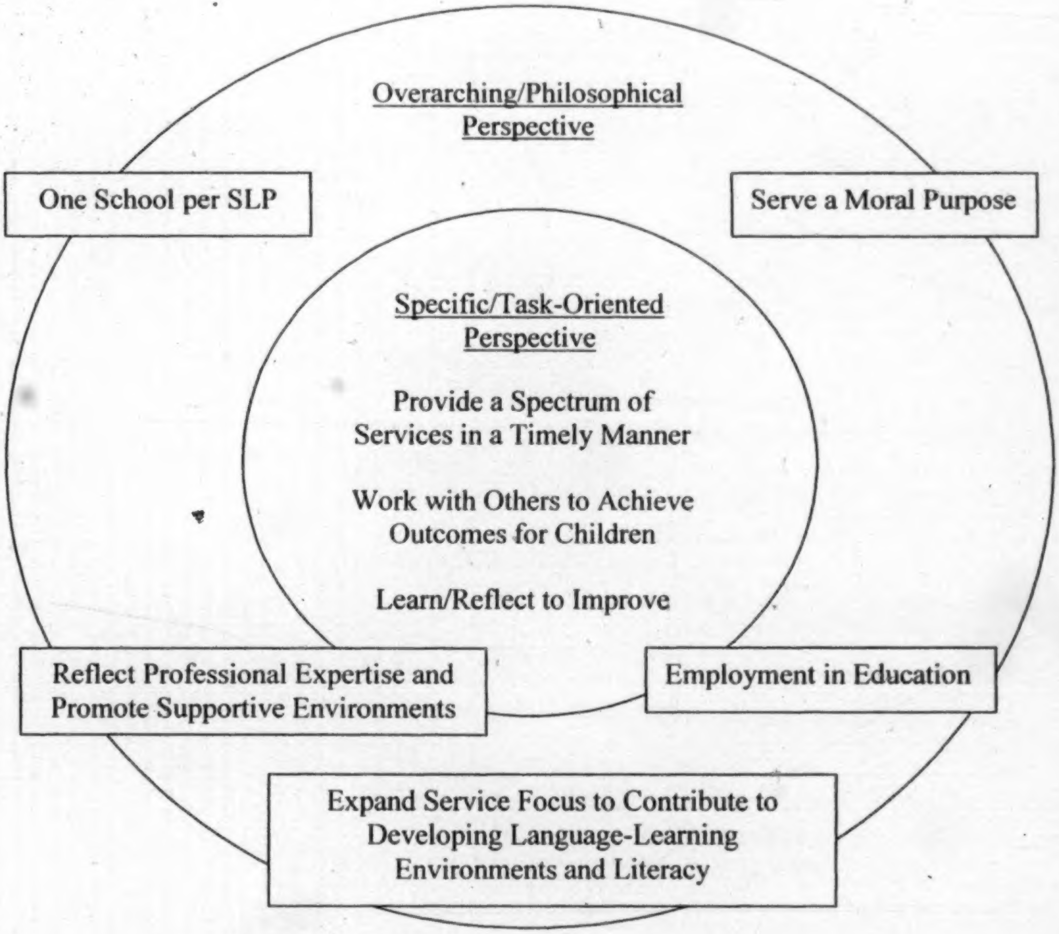
Specific/Task-Oriented Perspective

Three categories of data were found to reflect a specific/task-oriented perspective on the ideal role for SLPs serving school-age children. In other words, the data in these categories described "things to do" in the best possible practice.

Provide a Spectrum of Services in a Timely Manner

Some of the participants reported that a SLP serving school-age children would ideally provide a wider range of services than they were currently able to or as I have termed it, that SLPs would ideally provide a "spectrum of services". The sense of a spectrum was evident both in comments about the need for a flow of services from

Figure 1. Components of Ideal Role as Perceived by Participating SLPs


Overarching/Philosophical Perspective
One School per SLP
Serve a Moral Purpose
Specific/Task-Oriented Perspective
Provide a Spectrum of Services in a Timely Manner
Work with Others to Achieve Outcomes for Children
Learn/Reflect to Improve
Reflect Professional Expertise and Promote Supportive Environments
Employment in Education
Expand Service Focus to Contribute to Developing Language-Learning Environments and Literacy

identification through diagnosis to intervention and also in comments about the need for front-line SLPs to have a selection of intervention options to choose from to best meet the needs of individual children. I also identified a thread of "timeliness" running through these ideas about service provision. Both of the senses for "spectrum" and the element of timeliness are discussed in the following sections.

Promote Appropriate Identification and Diagnosis

Participants singled out identification and diagnostic procedures as areas in need of special attention both in terms of types of activities conducted and timeliness of activities. For example, S4 spoke of how appropriate identification would ideally be supported by the SLP providing in-services to school staff on what to look for and how to refer. This participant also stated a personal opinion that screening initiatives were likely more important in identifying children in need of services than currently credited by professionals working with school-age children. S4 went on to specify a need to supplement these formal communication opportunities with ongoing, informal contact with individual teachers in order to ensure timely referrals of children with more subtle needs.

In the area of diagnostics, S4 reported that a SLP would ideally spend more time on teacher concerns prior to beginning formal assessment of a child, in order to ensure that the presenting concern was in fact best addressed by a SLP and not another professional, such as an educational psychologist. S12 reported that ideally a SLP would also meet with each teacher to adjust assessment practices to the case.

It was not surprising that SLP participants highlighted identification and diagnostic procedures in their service responsibilities for the school-age population because these activities were identified in the literature review as important responsibilities of SLPs when serving any client population and significant time consumers for SLPs serving school-age children. Within the identification process, SLP participants' emphasis on referral was supported by the literature as were their specific suggestions of improving referral practices by providing in-services and increasing the awareness of the broadened role for SLPs serving school-age children (ASHA, 1999; Campbell, 1999; Moore-Brown & Montgomery, 2001).

One of the participants specifically singled out screening initiatives for attention. Viewing screening activities as distinct from referral activities has support in the literature due to the fact as screening is typically an organized early observation process scheduled at a specific time during the year whereas individual referrals are addressed as they arise throughout the school year (Moore-Brown & Montgomery, 2001). The importance of screening activities as an adjunct to referral activities was emphasized by Nelson and Staskowski (2001), who noted that because communication is such a natural and pervasive phenomenon many people take it for granted and as a result referral sources may miss comprehension difficulties or blame them on behaviour issues and may also miss subtle language expression problems that may interfere with students' academic performance. It was just this subtlety that concerned the participant who highlighted screening as a component of the ideal SLP role. Given the current literature support for screening, S4's sense then that that speech-language pathology was making an ill-advised move away from screening could relate more to local time and caseload pressures than to a genuine shift in the broader SLP community. Anecdotal information suggested that, at the time of the study, few jurisdictions in Alberta conducted school-age screening for speech-language cases due to a lack of human resources to both execute the screening and to follow-up with identified cases.

It was particularly interesting that several participating SLPs chose to emphasize informal contact with teachers as part of their ideal role, promoting it as a means of improving identification of students. The role of general educators in identifying students who may need services has been emphasized by several authors (Campbell, 1999; Moore-Brown & Montgomery, 2001; Secord, 1999). However, although the importance of "friendly" contact with other professionals is often mentioned in introductory speech-language pathology and school-age practice texts, no research could be found identifying specific benefits of this informal contact between SLPs and teachers for students. Indeed, there was limited research on contact between SLPs and teachers in general. The research which had been conducted suggested that educators seek more meaningful and effective collaboration, involving more time commitment for SLPs to learn about curricula and classroom management techniques and to keep colleagues informed about treatment goals and procedures (Sanger, Hux, & Griess, 1995; Tomes & Sanger, 1985). While the available research did not completely answer questions about the role of informal contact between SLPs and teachers in breaking down barriers to collaboration, it did suggest that the type of informal contact highlighted by participating SLPs would not be sufficient in and of itself.

Within the diagnostic process, participating SLPs' comments specifying spending more time determining teacher concerns prior to and during this phase of service as part of their ideal role when serving school-age children were supported by the practice literature. For example, Nelson and Staskowski (2001) stated that discussions with teachers provide "critical information to guide comprehensive assessments, document disabling effects, and help to differentiate language disorder from language differences"

(p. 279). These authors went on to note that through these discussions, SLPs can discover the educational contexts that present the most difficulties for the student and the communication skills that would make it easier for the student to participate appropriately in those contexts. Eger (2001) emphasized that point stating that thorough evaluation "requires input from the student's teacher(s) to verify the impact of any communication concerns on the student's academic performance" (p. 257).

As previously noted, the diagnostic phase is an extensive part of SLP service to school-age populations. As such it encompasses numerous tasks. It was therefore striking that the participating SLPs singled out greater and timelier contact with teachers as a critical part of their ideal role in this phase. Because it was likely that participants were influenced in their selection of ideal role characteristics by their current practice situation, this choice suggested that these participants were currently concerned about their ability to work with teachers to ensure students' communication needs were appropriately diagnosed. The literature on workload has discussed the significant amounts of time that should be allocated to teaming with other professionals for each student added to a SLP's caseload (i.e., ASHA, 2002a, 2002b, 2002c; Cirrin, 2004, Moore, 2004). How to best set this time aside when SLPs are under increasing pressure to provide more students with diagnostic and intervention services remains a vexing question.

Other than obtaining more input from teachers, participating SLPs did not refer to any particular methods of assessment when discussing their ideal practice with school-age children. While standardized tests and observation are longstanding parts of SLPs' assessment repertoires, other methods are becoming more widely discussed in the literature, such as performance-based measures (including curriculum-based tests), dynamic tests, and review of student products (Moore-Brown & Montgomery, 2001). That none of these methods were singled out by participants when discussing their ideal role did not prove by any means that they were unfamiliar with these methods. Participating SLPs also did not make any mention of the importance of carefully selecting assessment measures appropriate to particular clients nor did they note the need to incorporate other sources of information (in addition to teachers) to provide a balanced evaluation of students' communication. Again it was possible that these role components were not highlighted by participants because they were already successfully incorporating them into their current practice.

Provide Most Appropriate Intervention to Each Child

Participants acknowledged that providing the most appropriate type of intervention to each child was part of the ideal role for SLPs working with school-age children. For example, the visions of ideal service articulated by S9 and S11 included being able to provide a range of intervention services from direct one-to-one service to consultation to team-teaching. Both of these participants reported that such a range was required to best meet the varying needs of the presenting children. The need to provide this "spectrum of services" was supported by the literature (Blosser & Neidecker, 2002; Meyer, 1997a, 1997b; Pershey & Rapking, 2003) as was the wide variability in student needs (ASHA, 1999; Cirrin et al., 2003; Harn et al., 1999; Moore-Brown & Montgomery, 2001; O'Connell, 1997). Indeed, the available information on Canadian SLPs' practice with school-age children suggests that many are attempting to provide a range of intervention services. As noted in the literature review, 67% of respondents to CASLPA's *2003 Caseload Guidelines Survey* used three or more service delivery models when serving school-age children.

While a need for some interventions for school-age children to be classroom-based was frequently mentioned by participants, they also spoke out for a need to continue providing "more traditional" one-to-one interventions or "pull-out" interventions as required to meet children's needs. They argued that this type of service provision was a critical and unique part of their ideal role as SLPs. Once again, the comments of the participating SLPs were echoed in the literature. Nelson and Staskowski (2001) acknowledged several advantages of pull-out services including increased opportunities for students to talk and to receive immediate feedback in a safe environment, ability to provide repetitive practice when students must acquire new motor skills to address articulation, voice, or fluency needs, and privacy when intervention exercises would be conspicuous or embarrassing to students. In addition, Meyer (1997b) noted that the pull-out model allows for the provision of focused, intense intervention and can be judiciously used in combination with classroom-based interventions that encourage more generalization of skills. Blosser and Neidecker (2002) acknowledged pull-out interventions as being historically the primary model used by SLPs to deliver services in school settings, giving credence to the participating SLPs' conceptualization of this style of service as a critical and unique part of their ideal role as SLPs.

The need to be able to choose between direct and more indirect (consultative) forms of service was strongly highlighted by participants. Some participants specified direct service as being able to intervene directly with students themselves while others reported that treatment provided by paraprofessionals could be an appropriate form of direct service. In terms of the ideal including the SLPs themselves intervening directly with students, S6 provided three reasons why it was important to retain this part of their role, arguing that it allowed new graduates to gain practical experience, kept more seasoned professionals in touch with the realities of clinical practice, and provided all with a source of personal satisfaction critical to decreasing burnout. S2 went further in arguing that students would potentially benefit more from direct intervention services by a SLP because quality control would be higher, allowing students to make progress more efficiently. S2 acknowledged that this was a personal opinion and stated that the SLP profession needed to collect data to support her perceptions.

That SLPs would provide some form of direct intervention service when working in schools appeared to be an assumption in the speech-language pathology literature. Huffman and O'Connell (1997) called direct student services a "hallmark" of school speech-language pathology. Harn, Bradshaw, and Ogletree (1999) argued for a three-way split in the role of a SLP in school-age practice between "direct service provider", "collaborator/consultant", and "supervisor" and reported that direct service would be provided to at least some of the children. The assumption that collaboration and consultation would "supplement" but not replace direct forms of intervention was also evident in the most recent relevant documents from the national professional associations (ASHA, 1999, CASLPA, 2004a).

Provide Timely Service

For participants, timeliness in providing intervention services related both to promptness of all service provision and to achieving the most appropriate frequency of intervention services. Three of the participants specified that providing needed services promptly was part of their ideal role. S4 and S13 specifically mentioned seeing new referrals for assessment in a timely manner. S7 extended this responsibility to reducing waiting times for treatments and reviews as well. S13 went further, noting that providing intervention services with the most appropriate frequency was also a component of ideal practice. These concerns about timely service relate to acknowledged SLP responsibilities for caseload management. Canadian standards of practice (CASLPA, 2004a) recognize caseload management as a responsibility of SLPs. The American Speech-Language-Hearing Association (1999) has specifically singled out coordination of the overall service program as a SLP responsibility. A preoccupation with timely service also suggests the importance of scheduling as a SLP role. Moore-Brown and Montgomery (2001) concluded that SLPs need to carefully schedule their time and duties to do their jobs successfully, especially if they are working at multiple sites.

Promptness of service provision is an oft-discussed topic in the international speech-language pathology practice community as in other predominantly health-based professions. American federal education laws currently require that school districts complete evaluations and make services available within a "reasonable period of time" after parental consent is obtained with specific timelines varying from state to state but typically between 30 and 60 days (Moore-Brown & Montgomery, 2001). However, these timelines did not appear to be based on research demonstrating any particular risk of waiting longer for services. In 2004, when the first field research for this study was conducted, the Pan-Canadian Alliance of Speech-Language Pathology and Audiology Associations had just convened a Wait Times Task Force. Creation of the Task Force was considered timely in light of the federal and provincial governments' focus on wait times in health care. The Task Force was charged with recommending evidence-based wait times for various speech-language pathology and audiology procedures. The Task Force's ultimate success in fulfilling this mandate was still an open question at the time of this writing but its creation by the Pan-Canadian Alliance underscored promptness of service provision as a topic of high importance in the Canadian speech-language pathology community.

In addition to seeing students promptly, one participating SLP identified an additional timeliness factor in the need to carefully consider optimal intervention frequency. Specifically, S13 reported that seeing students more than once a week would be ideal, even if it meant trading time per session for frequency. Efficiency was the main perceived benefit of such an arrangement for speech cases, while greater ability to fine-tune intervention was seen as the main benefit for language cases. S13 also stated that all students would benefit from more frequent service because the SLP would have more contact with their teachers and more knowledge of what was going on in their classrooms allowing her or him to more readily tailor the speech-language lessons to classroom topics and issues. Time-sufficiency of SLP service has been documented as an issue for educators. Sanger, Hux, and Griess (1995) found that educators were uncertain about the adequacy of the length of time SLPs spent with individual children. Moore-Brown & Montgomery (2001) specified appropriate scheduling of interventions as a key responsibility of SLPs, noting that changes in service delivery models throughout the school year would be necessary to best meet students' needs and that the SLP scheduling must remain flexible.

Interestingly, in the discussions centering on timeliness of services, participating SLPs were inclined to state that timely provision of service was important without specifying strategies for addressing the issue. This pattern contrasted with that noted during discussions of other concerns, during which the SLPs typically provided several suggestions for addressing each issue. In the literature, the use of a pre-referral process (Moore-Brown & Montgomery, 2001), prioritization for interventions (ASHA, 1999), and monitoring as an intervention strategy (Blosser & Neidecker, 2002) have all been considered as strategies contributing to timely service. It was not apparent if any of these strategies were currently in use in the front-line practice of participating SLPs.

Work with Others to Achieve Outcomes for Children

As participants discussed the importance of working with others to achieve outcomes for children, three groups were specifically mentioned. In the following sections, I discuss the resulting categories related to working with assistants, school staff members, and families.

Supervise Assistants

Six of the fourteen participating SLPs specifically remarked on the use of assistants when discussing their visions of ideal practice with school-age children. For example, S12 and S14 both commented on the importance of a specific and circumscribed role for assistants with S12 indicating that the ideal would be "to have well-trained assistants who can assist but not take over the caseload (Int 1 LN 332-348)" and S14 highlighting the responsibility of SLPs to delegate to assistants only tasks within their scope of practice and to supervise them appropriately. S14 also specified that close supervision was important both to ensure child progress and for the assistants' professional growth and development.

Two specific factors related to the use of assistants were identified by participants as critical to allowing SLPs to achieve their ideal role with school-age children. The first factor was the adequacy of the assistant time dedicated to a SLP. "Dedicated assistant time" meant to participants that they were designated as supervisor for a specific block of the assistant's time and were able to delegate tasks to be completed during that time as they saw fit. The second factor was a preference for working with assistants employed by the same health region instead of with teaching assistants employed by the school boards. This preference was strongly expressed by two participants; S6 and S7 both equated health region-employed assistants with better training and experience and therefore of providing more benefit to the supervising SLP and to the children served. They argued that this second factor was related to the first because SLPs were more likely to obtain "dedicated assistant time" through their own health region employer.

In recent years, the practice literature has increasingly documented working with support personnel as part of the role for SLPs working with school-age children. Indeed, Cascella, Purdy, & Dempsey (2002) listed working with support personnel as one of the central practice challenges in modern speech-language pathology. Henri and Hallowell (2001) referred to support personnel as "care extenders" and noted that their use might help reduce the limited access to professional care that has become increasingly common across North America. Lending support to the perceptions of participating SLPs, these authors supported a specific and circumscribed role for support personnel, noting that they may provide services that do not specifically require the skills and expertise of professionals on an ongoing basis, thereby freeing up the professional to treat individuals with more severe and complex communication disorders and improving the overall quality of care. The need to carefully supervise support personnel has also been emphasized by professional organizations, provincially (ACSLPA, 2006), nationally (CASLPA, 1995, 2004b), and internationally (ASHA, 2002d).

While participating SLPs appeared to be largely consistent with the practice literature in their acceptance of the use of support personnel as part of their ideal role with school-age children, the two factors they mentioned as critical to allowing them to fulfill this role component in an ideal manner were not addressed by the practice literature. Authors appeared to presume that support personnel would be assigned specifically to supervising SLPs and that these support personnel would be employed by the same agency as the supervising SLPs. Sharing of support personnel supervision with others (i.e., other SLPs, rehabilitation specialists, or teachers) and supervision issues arising when SLPs and support personnel work for different employers had not been addressed by researchers at the time of this writing. CASLPA's 1995 *Position Paper on Support Personnel in Speech-Language Pathology* partially addressed supervision issues arising when SLPs and support personnel work for different employers by noting that if a SLP was contracted to a school board as a consultant, support personnel could be used by consultees (e.g. classroom teachers) to support the delivery of intervention programs. SLPs could provide direct supervision of the support personnel in conjunction with the consultee but the consultee would retain ultimate responsibility for the student's program. Interestingly, CASLPA's 2004 document *Supportive Personnel Guidelines: Working with SLPs* focused more on support personnel training and responsibilities and less on specifics of SLP supervision and did not include the previous reference to supervision by SLP consulting with educators (CASLPA, 2004b). A 2006 revision has provided no further clarification of this area of practice. In this study, participant-specified factors of "dedicated assistant time" and health-region employed assistants appeared very much related and also alluded to particular issues arising with practice in educational settings.

Work with School Staff

Six of fourteen participants emphasized building a good relationship and ongoing communication with school staff as parts of the ideal role for SLPs working with school-age children. S4 and S12 spoke of a need for SLPs to take specific measures to build trust and to increase the comfort level of teachers. S11 provided an example of how this ideal teacher comfort level could positively influence service when she said that her hope would be to have teachers feel "comfortable enough to come up and ask you questions, feel comfortable enough about grabbing you in the hallway and saying, "Hey can you come take a look? Come sit in my class and take a look at this kid" (Int 1 LN 1040-1115).

Indeed, ongoing communication with school staff was viewed as important to all aspects of service. As discussed in a previous section, four participants emphasized the importance of communication with school staff in promoting appropriate identification and diagnosis. For intervention services, two participants discussed how ongoing communication with school staff could increase the relevance of interventions provided by speech-language program staff and carryover to classroom performance. S5 reported that it was ideal for teachers to "have some idea as to what's being targeted in Speech so if they see it in the classroom that they can reinforce it, you know, sort of have that connection with the teacher so that they know what you're working on with the child (Int 1 LN 590-621) and that it was important for SLPs to avoid being "just that person who knocks on the door, pulls the kid out for half an hour and brings them back and nobody knows what's going on" (Int 2 LN 812-828). Finally, S5 noted how ongoing communication with school staff provided itinerant SLPs with a critical link to parents and parental concerns because parents were more likely to approach the familiar classroom teacher with a concern than to try to track down the SLP. Participating SLPs' emphasis on ongoing communication with educators is consistent with the literature on the importance of collaborative planning (Blosser & Neidecker, 2002) and teaming (Huffman & O'Connell, 1997; Kennedy, 2002) in the provision of speech-language services to school-age children.

Participants also highlighted the importance of working together with school staff on interventions for children whether through team-teaching which was seen by three participants as providing a unique opportunity to work more closely with teachers to benefit students, especially those with language needs, or through what one SLP termed "hands-on consultation" with school staff about students with special needs. This SLP stated that this preferred style of consulting would involve meeting with both the teacher and the teaching assistant to provide specific goals and activities and to help them to understand the goals and went on to specify that while the teacher would then supervise the assistant working on the goals on a day-to-day basis, the SLP would provide most of the programming and check on its provision on a regular basis. To this participant another component of being "hands-on" involved SLPs deciding how specific and detailed to be in recommendations and suggestions for follow-through based on their professional judgments of the capabilities and responsiveness of school staff members. Participants' focus on working with teachers on interventions was supported by the abundant literature on classroom-based therapy and team-teaching (Blosser & Neidecker, 2002; Moore-Brown & Montgomery, 2001; Nelson & Staskowski, 2001). Indeed, the "hands-on" consulting style described by one participant was elaborated by Blosser and Neidecker (2002).

After reviewing the literature, it became clear that participants had not addressed two areas related to working with school staff. The first related to their apparent focus on collaborating with classroom teachers. No participants mentioned the importance of collaborating with other specialists or with school administrators even though the importance of broad-based collaboration has been emphasized in the literature (Blosser & Neidecker, 2002; Moore-Brown & Montgomery, 2001). The second area related to how participants mentioned many purposes for teaming but few processes. They appeared to fall back on informal strategies. After discussing the successful outcomes for students receiving collaborative speech-language services, Pershey and Rapking (2003) emphasized the importance of formalized support to ensuring that collaboration proceeds productively.

Engage Families

Engaging families in the assessment and intervention process was specifically mentioned by two participants as part of the ideal role for SLPs working with school-age children. For S12, engaging families during the assessment phase meant that the SLP would meet with each family after the assessment and that parents would have input into the goals set for their children. S4 specified that during the intervention phase the SLP would ideally have regular ongoing communication with families about student programs and parents would come in to observe sessions at least a few times each year and would understand and follow through with a home program.

This concern about engaging families was supported by the literature. Aligning with recent trends in other service professions (Sample Gosse & Phillips, 2007), Cascella, Purdy, and Dempsey (2002) specified family involvement as one of the top contemporary issues affecting the delivery of speech-language services, noting that the profession was negotiating how to include family members as integral participants in designing, implementing, and evaluating the effectiveness of treatment programs. The importance of involving families in the assessment phase was affirmed by Nelson and Staskowski (2001) who noted that "family-centered practices begin by discovering the communicative needs identified by the family and the concerns that family and student have for the student's success in the community, school, and home environments." They noted that family involvement in goal setting coming out of the assessment process would lead naturally to involvement in the follow-up interventions. Moore-Brown and Montgomery (2001) specified benefits of including families in the intervention process including the showing of respect for the importance of the family and increased generalization of targeted behaviors.

It should be noted that family involvement in the educational process is legislated in the United States (Moore-Brown & Montgomery, 2001). From this initial discussion with participating SLPs it was unclear if they were under any particular mandate from their health organizations to involve students' families in speech-language service provision. American SLPs have also been directed to develop partnerships with parents, families, and parent support groups to provide information on the prevention of communication disorders and the promotion of communication development and literacy skills and to advocate for the communication needs of students (ASHA, 1999). Participating SLPs did not specify these activities as part of their ideal role.

Learn and Reflect to Improve Practice

In our ideal role discussions, participants referenced a variety of activities with meanings clustered around the importance of continually seeking to improve one's practice through learning and reflection. Seven participants specifically mentioned that a SLP's role should ideally include time to research and obtain information needed to appropriately manage specific cases. S4 gave the example of searching for information about a specific genetic condition affecting a student. Taking time to reflect on practice was seen as an important part of improving it. This concept was exemplified by S4 who described this need for "Time to just be considering and looking back over things. If something hasn't gone as well as expected, what change do you want to make?" (Int 2 LN 407-519). Time was a crucial element. S14 spoke about how time to reflect was essential before front-line SLPs could apply the research literature and pursue excellence in practice. Other activities reported to encourage improvements to practice through learning and reflection were sharing information with others, participating in continuing education opportunities, and supervising student SLPs and assistants. For example, S4 related sharing with others to broad improvements in practice by noting that sharing went beyond sharing with other SLPs and singling out the importance of sharing information with and learning from other health and education professionals.

It appeared that participating SLPs had heeded Mustain's (2003) call for professionals in communication disorders to embrace lifelong learning. Indeed, Blosser and Neidecker (2002) wrote convincingly about the need for school SLPs to "keep abreast of new information by reading professional journals and publications, attending seminars and conventions, enrolling in continuing education programs, and sharing information or ideas with colleagues through state, local, and national professional organizations" (p. 16) and also noted supervision of student SLPs and assistants as a learning opportunity. All of these learning opportunities were mentioned by participants with the exception of utilizing professional organizations. The key need for time to reflect noted by participants was particularly supported by ASHA (1999) in their description of the role of SLPs as "evaluators" who "bring meaning to assessment data through interpretation, analysis, and *reflection*" (p. 19, italics added).

One area that has been emphasized in the literature but was not noted by participants is the involvement of front-line clinicians in research. Blosser and Neidecker (2002) urged school SLPs to become involved in research related to program organization and management, clinical procedures, and professional responsibility. Mustain (2003) argued that each practitioner had an ethical responsibility to evaluate not only his/her individual competence, but also the value of new clinical techniques to the populations served and that if insufficient evidence was found, the practitioner should personally acquire clinical data to contribute to the body of knowledge of the profession.

Overarching/Philosophical Perspective

Five categories of data were found to reflect an "overarching/philosophical" perspective on the ideal role for SLPs serving school-age children. In other words, the data in these categories described notions seen by these participants as foundational to the best possible practice.

One School per SLP

Two participants equated the ideal role with working in only one school. For S8, "one school per SLP" promised the feeling of doing an excellent job with both the teachers and the students and being a part of the larger school staff. This participant related this perception to increased opportunities to intervene directly with students, be more involved with classrooms and academics, have good relationships with teachers, and a good work space. S9 also reported that being at one school full-time would be ideal and highlighted that service improvements arising from such an assignment would all relate to having more time available to meet the needs of students and staff at that school.

It is likely that the participants were influenced by the American practice literature in their perceptions that one school per SLP would be ideal. The American practice literature often assumes that there will be at least one SLP per school. For example, Huffman and O'Connell (1997) described three employment scenarios for school SLPs; being in complete charge of a small school program, functioning as part of a large department in a large school district, or working as one of several SLPs within a school. There was no consideration of the possibility that a single SLP might serve up to eight schools or travel significant distances to numerous small rural schools as was the case in the health region studied.

There were also a clear "time and numbers" component to participants' perceptions in that it appeared that a major motivation for considering a one school allocation to be ideal was the idea that there would be more time available to meet the needs of a smaller pool of students. The general importance of time availability to ideal speech-language services has been supported in the literature (Niedecker & Blosser, 1993), and highlighted as a priority for enabling more collaborative forms of service delivery (Pershey & Rapking, 2003). As well it appears that participants were accurate in their perceptions that serving only one school would provide significant time advantages.

Pershey and Rapking (2003) reported that the travel between schools required when SLPs served more than one school took significant time away from therapy provision. Regarding the number of students to be served, it is clearly a reasonable expectation that with fewer schools would come fewer students just as multiple schools is typically synonymous with larger caseloads. Many authors have discussed the negative consequences of excessive caseloads for both SLPs and the students they serve (Huffman & O'Connell, 1997; Pershey & Rapking, 2003). Meyer (1997b) may have put it best by stating "An exhausted, overworked specialist puts the children he or she serves at risk." (p. 266). The participants who spoke of the ideal as "one school per SLP" clearly perceived that such an allocation would allow them to avoid this risk.

One participant spoke of how "one school per SLP" would allow the SLP to feel more like part of the school staff and that this feeling of belonging would facilitate better service to students. This notion too was supported by anecdotes in the literature. Moore-Brown and Montgomery (2001) have reported that in their experience having one school could enable SLPs to take on additional school service roles such as recess duty and coaching which provided the side benefits of increasing the SLP's visibility school-wide, offering opportunities to observe students communicating with peers, building staff relationships, attracting administrator support, and integrating the SLP into more aspects of the school and community.

Employment in Education

Although all the participants mentioned during my contact with them at least some desire to work more closely with education, four also specifically mentioned that they did not necessarily mean that they wanted to work for education. In contrast, one SLP categorically stated that "the ideal role for a school-age SLP is school-based not health-region based". For this participant, that was the absolute bottom line in terms of what was ideal. The SLP argued that there were philosophical differences between education and health and described health as "looking out for the bigger picture" or the needs of the population as a whole (S1 Int 1 LN 959-1034). The participant also reported that it was much easier to team with educators as someone from within the same organization. It is likely that this strong opinion and the comments were based on the SLP's personal experience of working for a school district and then serving the same schools as a health region employee. There is also a possibility that this participant was influenced, at least indirectly, by the use of "school-based SLP" as a professional classification in the United States. The American Speech-Language-Hearing Association (ASHA) typically refers to SLPs who are employed by school districts to work with students as "school-based SLPs". This concept of "school-based SLP" has been well-developed in ASHA's literature, most especially in the 1999 document, *Guidelines for the Roles and Responsibilities of the School-based Speech-Language Pathologist.*

The participant's perception that SLPs serving school-age children would ideally be employed by education authorities seemed to relate to her sense that it was critical to understand and be a part of the education organization when serving its students. This idea was supported by Moore-Brown and Montgomery (2001) when they noted that "the world of schools requires a specialized understanding of how 'the system' works and what it means to be an employee in a public school. Understanding the requirements of the school environment will help SLPs be more effective and make meaningful contributions to the students and staff there" (p. 271). As noted in the literature review, however, there are no studies contrasting the speech-language services to students provided by health-employed SLPs versus education-employed SLPs so this participant's assertions of education employment as ideal have not been substantiated.

Reflect Professional Expertise in Service and Promote a Supportive Environment

S3 also articulated an overarching philosophical ideal role for SLPs serving school-age children. For this participant, ideal practice with school-age children meant providing service that reflected SLP expertise in language and speech development. This philosophy was described as meaning that sometimes direct treatment was most appropriate while at other times, providing assistance to teachers in writing the student's IPP was more valuable. S3 paired this philosophy with a call to ensure that all SLP actions continually promoted an environment for the child supportive of his or her language and speech development.

S3's expressed approach to school-age practice was supported by the literature. A significant part of this participant's ideal approach was addressing the child's environment. Sonnenmeier and McGuire (1995) stressed that it was the job of SLPs to create opportunities for all individuals to demonstrate their skills, using chronologically age-appropriate materials, and under conditions of high expectations and that a SLP's goal should be to support all efforts in this regard, not only to provide intervention (Meyer, 1997b, p. 258). O'Connell (1997) reinforced the need for SLPs to view individual students within the total school environment with all of the concomitant linguistic demands and to provide services that were integrated with and crucial to the entire educational experience. The second major component of this participant's approach was keeping the emphasis on speech and language expertise. Addressing SLP participation in the development of individualized education plans, Blosser and Neidecker (2002) highlighted the speech and language expertise of SLPs by describing how SLPs could explain or demonstrate specific techniques that teachers and parents could use to assist students in carrying over appropriate language skills into everyday life, provide informal analysis and suggestions for modification of the classroom environment, the teacher's communication style and delivery, or language-learning strategies for students. Moore-Brown and Montgomery (2001) emphasized the importance of SLPs using their knowledge of social communication to understand the big picture of the impact of a student's disability on relationships both at school and at home.

Expand Service Focus to Contribute to Developing Language-learning Environments and Literacy

S14 also embraced a philosophical basis for school practice. For this participant, however, ideal service maintained a "traditional" focus on identification of, and specific interventions for children with communication disorders and expanded the role of the SLP to address at-risk populations and students having difficulty with literacy. The ideal role for a SLP in schools was described as including the provision of both informal and formal education to teaching staff to increase their understanding of language issues affecting these populations. Working within this participant's ideal role, SLPs would strive to build an understanding and awareness in teachers of their expanding role, including engaging in discussions with teachers about how "language doesn't mean language arts, and speech and language pathologists do more than treat R's and S's and stuttering, and what our role is in the reading and writing piece" (Int 1 LN 943-1003). Working with teachers to enhance the language learning environment within the whole school and not just for specifically identified children was also part of this SLP's ideal.

Such efforts were seen as allowing SLPs to reach "not only the kids who were referred but all those other kids sitting in that classroom who also need enrichment and support in their language learning" (Int 1 LN 943-1003).

S14's consideration of SLP involvement with literacy development as ideal has been supported in the literature over the past 15 years. At first, SLPs were called upon to provide and assist with phonological awareness training for students (Catts, 1991) but gradually the broader contribution that their knowledge and skills in speech and language development could make in addressing written language disorders came to be recognized (Apel, 2002). Indeed, in testimony to this broadened SLP involvement with literacy, by October 2004 a literacy-focused edition of the newsletter of ASHA's Language Learning and Education special interest division included articles about SLPs addressing parental beliefs about literacy learning in non-majority households, enhancing literacy development in preschool-age children at risk for reading difficulties, word study, and negotiating their role in school literacy instructional efforts (ASHA, 2004c).

Other components of S14's ideal role for SLPs have also received support in the literature. The notion that it was also important for SLPs serving school-age children to maintain a traditional focus on intervention for children with communication delays and disorders has been supported by researchers who have acknowledged a relationship between early childhood language development issues and later difficulties acquiring literacy. For example, in the United States, the National Council on Preventing Reading Difficulties in Young Children ranked identification of and service to children with language problems by SLPs as the second priority in a long list of critical recommendations for prevention (Snow, Burns, & Griffen, 1998). As well, numerous sources including ASHA (2001a) and Apel (2002) have urged SLPs to communicate with teachers about how the role of SLPs in school settings has evolved to include a greater emphasis on language and literacy needs. S14's expansion of the role of SLP in literacy development to encompass the entire school community was consistent with ASHA's (1999) call for SLPs to embrace the goal of establishing an educational environment that allows for maximum practice and development of all language skills whether through reading, writing, listening, and speaking. Ultimately, in 2000 ASHA specifically noted that SLPs make a contribution to the literacy efforts of a school district or community on behalf of all children and adolescents not just those with communication disorders.

There were potential gaps in S14's philosophy – at least as articulated in the first interview. At that time, S14 emphasized the SLP's role in literacy but provided no specifics about what that would look like, other than educational activities to raise the awareness of educators of the links between language and literacy and the role of the SLP. Numerous other responsibilities for SLPs regarding literacy, including collaborating with school personnel in the development of literacy programs, participating in the selection of modification of language arts curricula, providing information and support for parents of at-risk children regarding the importance of literacy activities within the home environment, providing intervention by teaching phonemic, syntactic, morphemic, and semantic aspects of language in both oral and written modalities, and assisting in the development of students' oral and written discourse skills have been acknowledged (ASHA, 1999).

All authors have acknowledged that the literacy development efforts of SLPs are best conducted in collaboration with other professionals. S14 alluded to this by discussing the need for greater educator understanding of the SLP role but did not speak to how SLPs would actually collaborate with those currently involved in literacy service provision. Indeed, negotiating SLP involvement in literacy service provision has generated considerable controversy in the practice literature. ASHA (2001b) specified that specific roles for those collaborating in literacy service provision would vary with settings and experiences of those involved. Blosser and Neidecker (2002) alluded to the possibility that language and literacy development for the school-age population might eventually become a specialty within speech-language pathology. Ukrainetz and Fresquez (2003) noted that while the widening horizon of SLP practice was justified theoretically, in practice the resultant role overlap with other school personnel could be a dangerous source of role ambiguity and conflict heightening the risk of SLP burn-out potentially without cause as there was currently no conclusive evidence that role-sharing around literacy development resulted in greater benefits to children than does separate practice.

Serve a Moral Purpose

During the time I spent with S13, I identified a "moral" orientation to practice as reflected in this participant's emphasis on the importance of maintaining "a sense of helping, a sense of doing good, a sense of adding something to the world" as the ideal role (Int 2 LN 633-686). When later questioned about whether having a moral purpose "encompassed" ideal practice, S13 reported preferring the term "influence" to "encompass" and went on to describe a "moral compass" as affecting day-to-day work but not directly controlling it (S13 personal communication, January 27, 2006). Indeed, S13 eloquently described it as akin to how the world appears in the warm light of an August sunset and noted that just as the quality of light changes throughout the day, morality can have a transient effect in our daily lives as our mindfulness about what we are doing and why we are doing it varies. After further discussion, we agreed that the desire to serve a moral purpose as an SLP could be likened to a lens that one sometimes looks through. S13 further articulated that the moral way of looking at life was bigger than individuals and existed independently of them, yet we each have the ability to make it part of how we live our lives. This participant also noted that maintaining a moral outlook takes practice and returning to the lens analogy, stated that we may carry the "moral lens" around in our pockets for a while, pulling it out when we remember that it can help us look at situations, before the moral way of looking at the world becomes intrinsic to how we operate as professionals.

The concept of SLPs having a "greater good" or moral purpose when providing speech-language services is not a new concept in the literature. Catt (2000) described SLPs who intervene on behalf of those with communication disorders as serving a moral purpose and as forming a greater moral community. She noted that as moral characters, SLPs are subject to the mores of the greater community (cultural, national, linguistic, religious, professional, etc.) and therefore serve a moral purpose in that community. The source of those moral obligations was described as residing in the client-clinician relationship.

A moral purpose for SLPs also appears tied to discussions of what it means to be a clinician and of how ethical practice is defined. Paul (2002) emphasized the importance of clinicians having "humanist" qualities in addition to technical proficiency. Kamhi (1994) wrote of caring and compassion as significant parts of a "therapeutic attitude" essential for providing high-quality speech-language services. Specific to the Canadian context, Eadie and Charland (2005) noted the CASLPA's Code of Ethics specified four values – two which emphasize the importance of technical/professional skills – “Professionalism” and “High Standards and Continuing Competency” and two that emphasized the moral foundation for the professional – “Integrity” and “Caring and Respect.” Stewart’s 2006 model of ethical practice in paediatric speech-language pathology specified making a difference in the lives of children with communication disorders by ensuring that these children are part of their social world, socially connected to others, as the moral aim of clinical practice. Ethical paediatric SLPs were described as those who value the child and strive to do their best for the child and his family (Stewart, 2006).

Clearly, an orientation to the profession that includes a sense of moral purpose was supported by the literature. S13 seemed almost tentative, however, in suggesting that a moral orientation existed and how the moral orientation was being actualized in practice was not made explicit. Catt (2000) specified that as moral professionals SLPs would hold client interests paramount over their own interests and would seek to expand the knowledge base of the profession not for its own sake but for the good of individuals with communication disorders. All of the perspectives and categories identified in the perceived ideal role of the front-line SLPs were consistent with a moral purpose for practice, even though only S13 specifically identified a moral orientation.

Summary and Discussion of Perceived Ideal Role for Front-line SLPs

While the two types of perspectives on ideal roles for front-line SLPs at first appeared somewhat contradictory, upon further reflection I realized that their presence represented a truth about front-line practice. That is, front-line practice requires both macro- and micro-management - taking a more global view of services to be provided as well as attending to the specifics of day-to-day practice.

When the perceived ideal role data was considered in its entirety, two themes emerged. First, there was a strong service orientation to doing “what was best” for clients by determining their unique needs and providing services to specifically address those needs. Face-to-face intervention appeared intrinsic to this orientation. Most participants highly valued direct intervention by SLPs but also recognized the role of support personnel in assisting with this intervention. The client-focus did not just relate to the individual. Participants recognized that serving the client effectively involved working with important others in their lives, including those within their schools and families, throughout the process. Interestingly, this service orientation was strikingly consistent with the ethical paediatric SLP practice described by Stewart (2006).

This client-focus was paired, however, with a certain amount of ambiguity about their professional role. Although participants raised numerous salient and important components of an ideal role of SLPs serving school-age services, not one participant appeared able to completely reconcile the need for both global considerations of service delivery and considerations focused on individual clients.

The discord apparent between the two identified themes of doing "what was best" and ambiguity about how to achieve that goal harkened back to the potential conflict between perceived ideal work role and currently practiced work role ascertained in the literature review and raised questions about if and how this discord would reveal itself in current practice. The extent to which the themes were evident in the SLPs' current practice and work context was investigated in subsequent phases of this study.

CHAPTER SIX: FINDINGS AND DISCUSSION - CURRENTLY PRACTICED ROLE

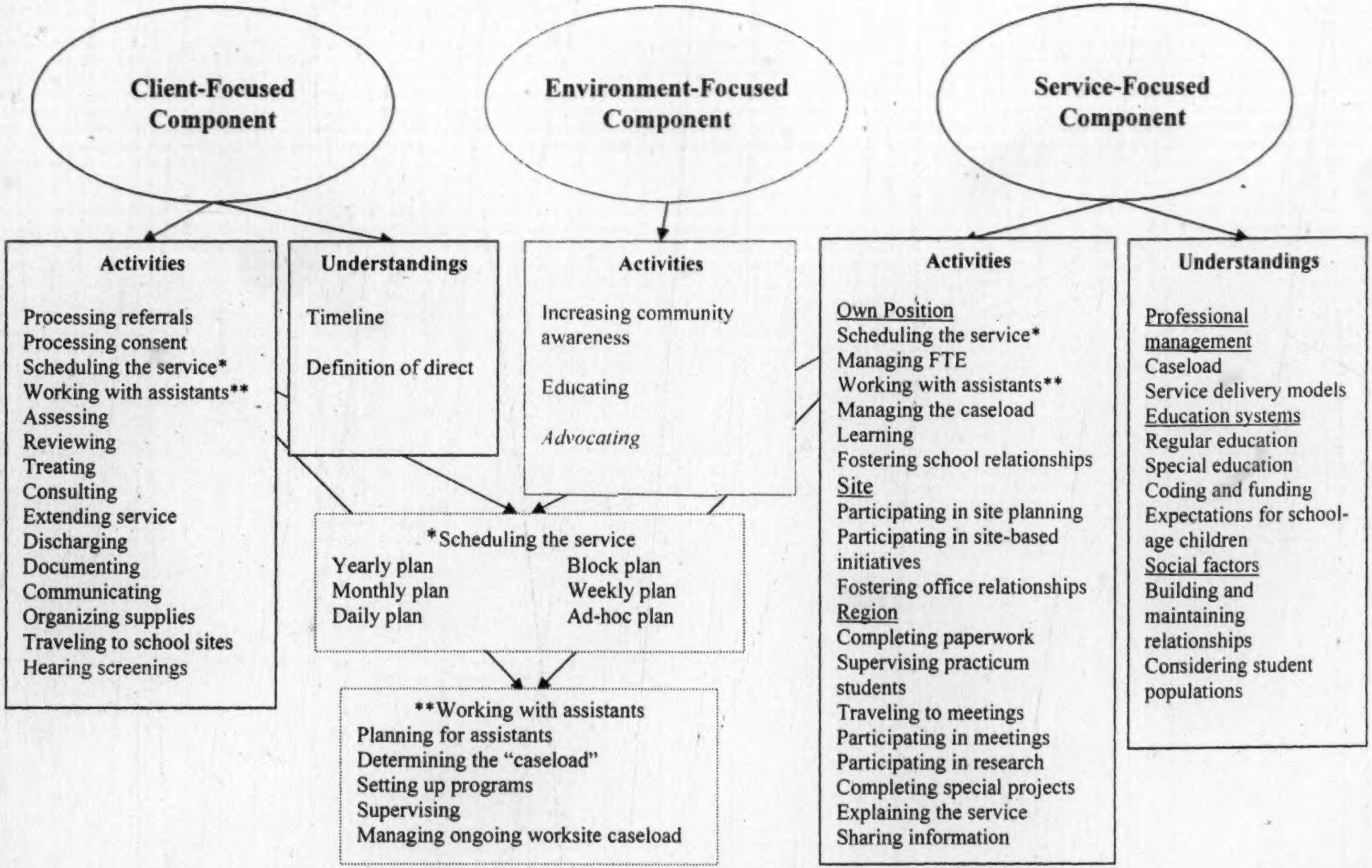
"I need to have copies of these piles to show everybody the piles of things that I do!"
(S10 U1-SO-T Int 2 LN 1027)

In this chapter, I present a detailed description of the actual practice activities completed by the participating SLPs. I also discuss some of the understandings that informed their practice. Together these elements of activities and understandings are used to portray the participating SLPs' role as currently practiced.

Figure 2 on the following page represents my conceptualization of the data related to participating SLPs' currently practiced role. Each of the three ovals represents a component of their practice. SLP activities and understandings necessary for serving individual students were grouped together as *Client-Focused* whereas SLP activities and understandings related to the service delivery system as a whole were grouped together as *Service-Focused.* During the data collection process, some SLP activities appeared to influence the overall environment in the schools served and in the broader community. I initially grouped these as *Environment-Focused*, however data support for this component remained limited and participating SLPs failed to verify this categorization during participant checks. As a result, environment-focus is considered as a "shadow" component and the oval is greyed out in the diagram. The solid boxes in the diagram represent the activities and understandings clustered within each component. *Activities* was used to refer to the actions completed by participating SLPs in their work while *Understandings* was used to refer to the key concepts or knowledge that informed the SLPs' work activities. During data analysis, two activities, *Scheduling the Service* and *Working with Assistants* were identified as having both client- and service-focused aspects. Because of this dual focus and the pervasiveness of these activities in practice, they were selected for more detailed analysis of tasks. The tasks identified for these activities are represented in the two segmented boxes.

I will begin by addressing the client-focused and service-focused areas separately - describing the relationship between activities and understandings and comparing current results to those expected based on the literature review. Because of the number of practice activities identified, information on tasks and considerations within the activities will be condensed.

Figure 2: Currently Practiced Role of Front-line SLPs


Client-Focused Component
Environment-Focused Component
Service-Focused Component
Activities
Processing referrals
Processing consent
Scheduling the service*
Working with assistants**
Assessing
Reviewing
Treating
Consulting
Extending service
Discharging
Documenting
Communicating
Organizing supplies
Traveling to school sites
Hearing screenings
Understandings
Timeline
Definition of direct
Activities
Increasing community awareness
Educating
Advocating
Activities
Own Position
Scheduling the service*
Managing FTE
Working with assistants**
Managing the caseload
Learning
Fostering school relationships
Site
Participating in site planning
Participating in site-based initiatives
Fostering office relationships
Region
Completing paperwork
Supervising practicum students
Traveling to meetings
Participating in meetings
Participating in research
Completing special projects
Explaining the service
Sharing information
Understandings
Professional management
Caseload
Service delivery models
Education systems
Regular education
Special education
Coding and funding
Expectations for school-age children
Social factors
Building and maintaining relationships
Considering student populations
*Scheduling the service
Yearly plan
Monthly plan
Daily plan
Block plan
Weekly plan
Ad-hoc plan
**Working with assistants
Planning for assistants
Determining the "caseload"
Setting up programs
Supervising
Managing ongoing worksite caseload

Specific numbers of participants conducting specific activities or holding certain understandings have been provided where possible and I have also noted when tasks were not only always completed even by those who did include them in their practice. However, my study was focused on obtaining as complete a qualitative description of the activities and understandings as possible so quantification by number of participants was not always compatible with that focus.

Client-Focused Component

As outlined in Figure 2, fifteen different categories of activities and two key understandings were identified as client-focused within the currently practiced SLP role. Each of these activities and understandings related to serving individual students.

Activities

Ten of the fifteen activities in the client-focused component were undertaken by all of the participating SLPs and were anticipated based on the literature review. Two of the activities identified as client-focused, Scheduling the Service and Working with Assistants, were also service-focused and therefore will be discussed later in this chapter in a section entitled Shared Focus Activities. The remaining three activities were conducted by only some of the participating SLPs.

Processing Referrals and Processing Consent

All participating SLPs processed referrals and consent. They affirmed that these activities were composed of the following tasks:

1. Processing referrals
    a. Interacting with referral source (sometimes completed)
    b. Providing paperwork (sometimes completed by either a support person or a key contact at the school)
    c. Reviewing paperwork
2. Processing consent
    a. Providing paperwork (sometimes completed by assistant)
    b. Reviewing paperwork
    c. Interacting with parent/guardian (may make phone call upon request)

While they sometimes delegated these tasks to support personnel or to school staff, they retained ultimate responsibility for the tasks. This responsibility was not entirely surprising as referral and consent activities have been discussed in the professional literature related to the identification process for speech-language pathology services (i.e., Moore-Brown & Montgomery, 2001). As well, the need to obtain informed consent from clients was addressed in the CASLPA *Canon of Ethics* in effect at the time of my study (CASLPA, 1999b). However, the extent of direct involvement by Canadian SLPs practicing with school-age children in referral and consent activities was not apparent in the limited Canadian practice literature. Lafargue and Vowels' (1985) workload evaluation described their participating SLP as spending 34% of her time on "non-direct-contact patient-related work" but referral and consent activities were not listed with the tasks in that category. Processing referrals and processing consent were also not addressed in *Assessing and Certifying Clinical Competency: Foundations of Clinical Practice for Audiology and Speech-Language Pathology* (CASLPA, 2004a*)*, often referred to in Canada as the "Foundations document" because of its use as a standards of practice document for professional training institutions and certified SLPs (CASLPA, 2004). Identification was listed in the *Scopes of Practice in Speech-Language Pathology and Audiology in Canada* (CASLPA, 1998) but no specifics were provided.

In my study, referral and consent activities were a significant focus for participating SLPs, particularly at the beginning of the school year. Their observed role was therefore more consistent with that described in the American document *Guidelines for the Roles and Responsibilities of the School-Based Speech-Language Pathologist* (ASHA, 1999) where review of referrals and obtaining parent/guardian consent were addressed within the identification role.

Participants did not always interact with referral sources prior to receiving a referral and often did not interact with the parents/guardians during the consent process. Both referral and consent were often handled through paperwork. Forms for both processes were provided by the health region. In addition, a health region letter describing the possibility of waiting for assessment and treatment accompanied the consent forms sent to parents/guardians. Several SLPs added a personal written message to the referral and consent packages. Person-to-person contact by meeting or phone calls between participating SLPs and referral sources and parents/guardians occurred only in cases where questions had been raised or problems had arisen.

The SLPs' relatively limited interaction with referring parents and teachers appeared inconsistent with their ideal vision of involving teachers and parents in the diagnostic and intervention process. Canadian standards did not provide enough detail to allow judgment of the appropriateness of how the SLPs handled referrals. In terms of the consent process, CASLPA's *Canon of Ethics* (1999b) indicated that consent could be verbal or written but did not specify how consent was to be requested.

Assessing

All participants participated in *Assessing.* They affirmed that this activity was composed of the following tasks:

1. Reviewing referral concern
2. Discussing with referral source (sometimes completed)
3. Determining order/priority
    a. Considering priority agreements between school boards and health region
    b. Considering school concerns
    c. Considering parent concerns
    d. Considering whether student potentially qualifies for Alberta Education program
    e. Considering grade placement (kindergarten students first)
4. Selecting techniques
5. Administering/carrying out techniques
6. Observation/Interaction
7. Analyzing information
8. Interpreting results
9. Communicating results

Making a diagnosis was not specifically highlighted by participants but seemed to be addressed within interpreting the data and reporting results. In comparison, the *Scopes of Practice in Speech-Language Pathology and Audiology in Canada* (CASLPA, 1998) referred to assessment activities but listed interpretation and diagnosis activities separately. The American guidelines document (ASHA, 1999) specified two separate roles in the area - assessment encompassed data collection activities including student history, nonstandardized, and standardized assessments while evaluation was used to describe interpretation and diagnosis activities.

Participants' consideration of interpretation and diagnosis as tasks within the activity of assessing was more consistent with the terminology used in the Canadian Foundations document (CASLPA, 2004a*)*, which used the term evaluation to describe the principles of clinical practice related to the assessment process including interpretation and diagnosis. The document also provided units addressing a variety of common communication and swallowing disorders and each unit included a section outlining practice tasks for the activity labeled as *Assessment*. In my study, the tasks practiced by the participating SLPs in the Assessing activity were consistent with the practice tasks under Assessment in the Foundations document (CASLPA, 2004a). While the Canadian Foundations document (CASLPA, 2004a) provided disorder-specific information, the American guidelines document (ASHA, 1999) provided more information about the specific assessment and evaluation considerations for the school-age population such as, for example, the need to consider the educational relevance of a student's communication difficulties. To determine a student's priority for assessment, all participating SLPs considered prioritization agreements negotiated between the health region and school district administrators. They also considered concerns of parents and school staff members as well as a student's potential eligibility for special education programs. They did not, however, appear to completely address educational relevance when collecting, analyzing and interpreting assessment data. All participating SLPs had access to information about educational relevance provided by parents and teachers during the referral and prioritization process but reported that they did not have adequate time to observe students in the classroom and consult with teachers as part of the assessment process. As a result, the educational relevance of a student's communication disorder could not be fully considered in the analysis and interpretation stages of the assessment process.

Also of interest, was the observation that participating SLPs did not always seek information from parents/guardians as part of the assessment process nor discuss the results of assessments with parents/guardians. All participants alluded to trying to find time to phone parents/guardians but only one insisted on conducting face-to-face meetings. All participants sent home assessment reports for parents to review. The appropriateness of these practices has been addressed in the section on *Communicating.*

Reviewing

The label *assessing* was used by all participating SLPs to refer to the first, and formal assessment of a newly referred student while *reviewing* referred to subsequent, less formal, assessments. All participants affirmed that Reviewing consisted of the following tasks:

1. Reviewing file
2. Discussing with teacher/parents (sometimes completed)
3. Probing
4. Communicating results

All participants' informal reviewing tasks included a review of the student's file and probing of his or her performance in semi-structured tasks or conversation. They sometimes discussed a student's case with parents/guardians and teachers to obtain their opinion on the student's progress but only when they were uncertain about whether further treatment was warranted. Similarly they often did not discuss their results and recommendations with school staff and parents but instead communicated through their reports. Exceptions occurred when the SLPs wanted to ask parents/guardians or teachers to help monitor a student's performance in the home or classroom. These practices are further considered in the *Communicating* section of this chapter.

Participating SLPs used reviewing to determine whether students still required treatment after they had been off for summer holidays or on treatment waiting lists. This organization appeared similar to that used in Lafargue and Vowels' 1985 workload evaluation where initial evaluations were differentiated from recheck evaluations. However, the more recent Foundations document (CASLPA, 2004a) mentioned the evaluation of progress towards goals in the clinical practice principle *Client Management* but otherwise did not single out functions similar to those identified by my participants under the activity Reviewing. The American guidelines document (ASHA, 1999) described re-evaluation as a SLP role but did so within the context of the formal individualized education plan team re-evaluation required by American education law.

Treating

At the time my field research was conducted only 5 of the 14 participating SLPs were actively engaged in the activity labeled as *Treating.* The remaining 9 participants were focused largely on assessing, reviewing, and working with assistants. Seven of these participants hoped to take treatment cases before the end of the school year, one was tied to a consulting role with middle school students, and one used a support personnel service delivery model exclusively. The 7 participants who hoped to take treatment cases all indicated that they would likely take only select and complicated cases. The specifics of the Treating activity observed in my study and verified by all participating SLPs were as follows:

1. Organizing Treatment
    a. Selecting cases (considered in conjunction with selecting cases for delegation to assistants – see Working with Assistants activity in Shared Focus Activities for details)
    b. Setting goals
    c. Considering grouping (sometimes)
    d. Scheduling
2. Providing
3. Evaluating Progress

The activity labeled as Treating by all participating SLPs was understandably the focus of a great proportion of the practice literature. While the tasks identified in my study matched quite closely with those in the literature, terminology was again inconsistent among sources. The same activity was variously referred to as therapy (Lafargue and Vowels, 1985), treatment and rehabilitation (CASLPA, 1998), and intervention (ASHA, 1999; CASLPA, 2004a).

Overall, the participating SLPs were far more involved with organizing treatment in their role as supervisors of support personnel (see the upcoming section Shared Focus Activities – Working with Assistants for more information). While this type of practice situation has not been reflected in the official Canadian practice documents (CASLPA, 1998; CASLPA, 2004a), it was reported by respondents to the recent *Caseload Guidelines Survey* (CASLPA, 2003). More than 8 in 10 respondents working mainly with school-age children indicated that they "worked in a consultative model in which they determined the intervention targets, procedures and contexts, but relied on another agent of intervention to carry out the program" (CASLPA, 2003, p. 18).

In a related anomaly from the practice literature, all study participants were heavily engaged in the task of selecting only certain cases for treatment from a larger pool. In this task, participating SLPs identified which students would receive treatment from available support personnel and which students they would serve if they had time to provide regular treatment. Because there were typically more students in need of treatment than openings in the treatment schedules, the task also involved determining which students would not receive immediate treatment. The SLPs received some guidance in this task from a health region priority ranking system but all considered additional factors as well (see the upcoming section Shared Focus Activities – Working with Assistants for more information). Neither Canadian practice documents (CASLPA, 1998; 2004a) nor the American guidelines (ASHA, 1999) referenced this type of case selection task.

Consulting

Consulting was considered a separate activity by all participating SLP and they all participated in consulting to some degree. Their consulting focused on making recommendations and working with others to improve and support a student's communication. All participants affirmed that Consulting encompassed the following tasks which would be conducted an as-needed basis:

1. Referring to other agencies
2. Providing recommendations
3. Providing ideas
4. Observing
5. Modeling
6. Providing resources
7. Suggesting strategies

Most of the students receiving this type of consultation service were students with severe disabilities attending special education programs within regular education settings or attending designated special education schools.

The tasks participants included within this activity were similar to those identified by Lafargue and Vowels (1985) as *counseling (parents, professionals, etc.)* and *consultation with professionals about patient* within the category of *non-direct-contact patient-related work* (p. 34). The Canadian scopes of practice document (CASLPA, 1998) did not use the term consulting but seemed to encompass the tasks under the headings of Treatment, Education, and Counseling. The American guidelines document (ASHA, 1999) addressed some of the consulting tasks conducted by participants in a discussion of collaborating with teachers and parents in the intervention process. In discussions about their practice, the SLPs did not use the word consulting to specify a treatment option. The terms *treating* and *treatment* seemed to be reserved for provision of one-to-one or group therapy by a SLP or support personnel. This terminology choice contrasted with the practice literature where consulting was typically considered a form of treatment and raised questions about whether the SLPs recognized consulting as a legitimate form of treatment, requiring the same level of progress monitoring.

Extending Service

I gave the label *Extending Service* to those tasks that 3 of the 14 participating SLPs were conducting or had conducted in an attempt to serve students who would otherwise remain on their treatment waiting list for more direct forms of service. The three SLPs who participated in the activity affirmed the following potential tasks:

1. Providing parent groups
2. Providing parent/home programs
3. Providing resource packages for schools

The fact that not all of the participating SLPs included this activity in their practice must be emphasized along with the fact that the three participants who did, did so only occasionally due to time constraints. In contrast to the other client-focused activities and tasks identified, the tasks verified by participating SLPs as part of the activity *Extending Service* were far less completely addressed in the literature. Neither the Canadian scopes of practice document (CASLPA, 1998) nor the Foundations document (CASLPA, 2004a) directly addressed these types of activities. Historically, Lafargue and Vowels (1985) alluded to the fact that the SLP participating in their practice review could not directly provide treatment for the majority of the cases, discussing *correspondence about patient* as non-direct-contact patient-related work (p. 34) and noting that the correspondence largely related to the need to explain, demonstrate, and forward speech-language programs to parents and/or other persons. Their work suggested that informally training other individuals to be the agents of change in treatment had a long history in Canadian SLP practice.

Discharging

Although I did not directly observe this activity, *Discharging* was added or confirmed as a client-focused activity by all participating SLPs when they reviewed the original activity listing for verification purposes. In their individual interviews, they provided information on the factors they considered in making a decision to discharge a student. Identified factors were as follows:

1. No consent
2. No needs
3. Determined ineligible
    a. Eligible for Alberta Education preschool program or regional consulting service
    b. Negligible progress
    c. Language skills commensurate with cognitive abilities
    d. Maxed out (re: health region service cap policy)

Discharging has typically been viewed in the literature as a caseload management function allowing SLPs to remove clients from their caseloads. In the Foundations document (CASLPA, 2004a), Canadian SLPs are charged with setting discharge criteria and modifying these accordingly under the Client Management section of the Principles of Clinical Practice and Professional Practice Issues unit. No official Canadian documents, however, provide guidance about the factors SLPs need to consider when discharging students from service. In contrast, the American guidelines document (ASHA, 1999) provided a page of information on the SLP role of *dismissal* specifying consideration of various factors including potential to benefit from intervention, student attendance, and parent and teacher involvement (p. 55). The specific lack of consent and lack of need factors identified by my participants would be consistent with any SLP's practice. Of greater interest was the participants' consideration of student ineligibility for services. This factor related largely to health region policies and procedures and revealed an aspect of the employer influence on front-line practice. This influence will be discussed in the following chapter on employment context.

Documenting

Observation and discussion with study participants resulted in detailed account of documentation demands for front-line SLPs. All participants completed the following *Documenting* tasks:

1. Recording time
2. Recording observations
3. Recording activities
4. Reporting results
5. Recording contact/communications
    a. Consultations
    b. Meetings
    c. Conversations
6. Filing of paperwork

Filing of paperwork was considered part of the documenting role as keeping organized and up-to-date files was critical to maintaining required documentation in a manner useful in practice.

The importance of the documenting activities identified in the practice of study participants has been validated in the literature. Related to documenting, Lafargue and Vowels (1985) listed *report writing* as non-direct-contact patient-related work and noted that the activity took a significant amount of the SLP's time. The *CASLPA Canon of Ethics* (1999b) specified the responsibility of CASLPA members to prepare and maintain adequate records of professional services rendered. The Canadian Foundations document (CASLPA, 2004a) used the term reporting and discussed related tasks within the unit Principles of Clinical Practice and Professional Practice Issues.

While a certain amount and type of documentation is required for ethical SLP practice regardless of setting, documentation policies, procedures and templates are also often provided and required by employers for use. Documenting, therefore, becomes an activity over which employers exert a significant influence. This influence will be discussed in the following chapter on employment context.

Communicating

All participating SLPs were observed communicating with the following type of individuals:

1. Principals/Vice-Principals
2. Key service contacts in schools (whether formally or informally defined)
3. Regular education teachers
4. Special education teachers
5. Parents

Communication with these individuals served a variety of purposes throughout service delivery to individual students from referral to discharge and, consistent with Lafargue and Vowels (1985), SLPs spent significant amounts of time on these communication tasks which were both verbal and written.

With regard to communicating, the Canadian scopes of practice document (CASLPA, 1998) mentioned the "provision of counseling and education services to clients, families, caregivers, and others regarding all aspects of communication and swallowing disorders" while the Foundations document (CASLPA, 2004a) discusses the communication of "assessment information to the client and/or family when appropriate, and to the referring agency and other professionals in accordance with guidelines for maintaining client confidentiality" (p. 26) but did not address communication for other purposes. The CASLPA *Canon of Ethics* (1999b) specified that members "shall provide information to the client regarding the nature of, services for, and treatment options for the client's communication disorder" and further that members "shall ensure that information provided to the client is accurate and truthful and is understood by the client."

It has already been noted that participants relied heavily on written communication in place of oral communication to convey many aspects of services, particularly to parents and teachers and that this was not part of their ideal practice vision. While Canadian standards documents do not specifically prescribe oral communication, the requirement in the *Canon of Ethics* (CASLPA, 1999b) that members ensure communication is understood raised questions about the participants' reliance on written communication. They appeared to rely on written communication because of time constraints and specified workplace practices. In terms of time, they simply did not seem to have enough to allow them to personally contact sometimes difficult to reach parents and teachers. Written communications, which could often be conducted en masse, had therefore become preferred for efficiency reasons. The policies and practices in their work context that facilitated or hindered participating SLPs' ability to communicate effectively with parents and teachers will be further considered in the following chapter.

Another aspect of *Communicating* that became of particular interest was the reports of three participating SLPs that they had become mediators between parents and teachers due to their involvement with both parties. To illustrate this point, one participant discussed meeting separately with parents and teachers to avoid parents "feeling ganged up on" when requested to attend a meeting with both the SLP and the teacher (P12 U2-SP-T Int 2 LN 250) and described mediating a dispute between the parents and a teacher about retaining a student in grade one. The triangulation of parent-teacher-SLP has been discussed further in the section on the education context in the following chapter.

Organizing Necessary Supplies

All participants spent time *Organizing Necessary Supplies* and they affirmed that this activity encompassed the following tasks:

1. Determining test/material needs
2. Accessing tests/materials from office site or other regional sites
3. Transporting tests/materials to and from schools and office sites

Participants borrowed infrequently-used tests from other sites. Because the majority of assessment and treatment activities were conducted at school sites, all participants needed to transport tests and materials to those sites. At times, this need necessitated making a special early morning trip to the office to pick up tests and materials prior to leaving for a school.

The need to organize necessary supplies was mentioned in the practice literature but not fully described or emphasized as part of serving individual students. For example, in 1985 Lafargue and Vowels indicated *preparation for therapy* as a task within the category of non-direct-contact patient-related work but did not specify any subtasks. The Canadian Foundations document (CASLPA, 2004a) discussed the need to prepare for assessment by developing a plan with appropriate clinical activities which was similar to the currently identified task of determining test/material needs within the activity of organizing supplies but did not address the other identified tasks of accessing tests/materials and transporting tests/materials.

Traveling to School Sites

All participants had to travel to school sites whether those sites were located in the same community as their site offices or out in the rural areas. Participating SLPs' concerns about traveling to school sites related to distances from office sites to school sites and between school sites, the resultant need to adjust work and lunch hours if SLPs wanted to arrive at schools prior to the start of classes, efficiency concerns related to the low numbers of students at small, rural schools versus the significant driving times involved in reaching the schools, and safety concerns related to winter driving.

The need to travel to school sites to serve students appeared to have been assumed but not discussed in the practice literature. Lafargue and Vowels (1985) acknowledged *travel time* under *departmental work*. In the course of my study, however, it became evident that all participating SLPs also traveled to attend working group and regional planning meetings and professional development opportunities in other centres. The portion of their travel which related directly to serving individual students was considered client-focused and given the activity label, *Traveling to School Sites*. Travel time for SLPs has not been addressed in any official Canadian document but did appear as a significant concern in the *Caseload Guidelines Survey* report (CASLPA, 2003).

Hearing Screening

Three participating SLPs were observed discussing the provision of hearing screening with support personnel so hearing screening was added as an activity. When the activity was presented for verification, however, all participating SLPs expressed uncertainty about their responsibility for the hearing screening process, noting that their assistants had been trained to conduct hearing screenings by the regional audiologist. Participating SLPs verified that they directed the assistants by providing them with the names of students who required hearing screenings for the purposes of speech-language assessment and sometimes discussed issues related to the provision of the screenings with assistants.

As a result of this situation, the hearing screening activity has therefore been presented as a "grey area" of unspecified responsibility within the practiced role of participating SLPs although hearing screening has been acknowledged in the literature as part of the SLP role. For example, the Canadian scopes of practice document (CASLPA, 1998) described the practice of speech-language pathology as including "screening of hearing and other factors for the purpose of speech-language evaluation and/or initial identification of individuals with other communication and swallowing disorders".

Understandings

Two understandings were identified as key to how participating SLPs addressed the client-focused component of their practiced role. The first understanding related to the timeline for service provision across the school year with the second relating to the SLP definition of direct service.

Timeline for Service Provision

Within the timeline for service provision to individual clients, participating SLPs identified a start-up phase at the beginning of each school year. Their activities within this phase were influenced but not entirely directed by priority agreements negotiated between health region and school district administrators.

All participating SLPs reported a personal responsibility to delegate intervention services to service personnel as early as possible in the school year. To do so, the SLPs needed to arrange to receive the required annual consent from parents/guardians, conduct reviews of returning students, select cases, schedule treatment, and provide information to assistants about goals and materials. Participants referred to this process as "getting the assistants up and running" and attempted to have support personnel start seeing students as early as the second week of the school year. The caveat was that after they had delegated intervention tasks to support personnel, the participating SLPs had to schedule time to supervise these individuals on a regular basis. They had to balance these support personnel-related tasks with the need to conduct the remaining assessments and reviews in a timely manner.

Their first assessment priority was kindergarten children with apparent severe delays who might be eligible for special education funding, then students entering grade one after having received special education funding in kindergarten, followed by students whose referral concerns appeared to place them in the mild-moderate range of delay (often beginning with the youngest students and working their way up through the grade levels). All participating SLPs noted that while these priorities were always considered in determining daily activities, what they actually did on any given day was determined by which students they had received consent to see and by student availability. Because of the number of schools and students participating SLPs were responsible for, this "start-up" assessment and delegation to support personnel phase often lasted into November of each school year.

For the remainder of the school year, participating SLPs anticipated that they would continue to spend some time on assessments and reviews as well as ongoing supervision of assistants. As previously described in the section on Treating, if they had not already done so, most participants indicated that they would attempt to find time to directly serve some students. Some participants also mentioned that they planned to spend more time consulting with teachers. Those who were using block scheduling for treatment activities indicated that they would have another busy period at the end of the first treatment block when they would need to write treatment summaries, select new cases, and provide information about goals and materials to the assistants. Block scheduling refers to providing intervention services to a set of students for a certain number of weeks known as a *block* and then switching to a different set of students for a second block. This type of scheduling will be further discussed in the *Shared Focus Activities* section under Scheduling the Service.

With experience with the caseloads to be served, some participants had adjusted their concept of the school-age service timeline in attempts to ease the workload at the beginning of the school year and provide the timeliest service to identified students. One participant conducted the bulk of the required assessments and reviews in the month of August, requesting that parents and caregivers bring students to the health unit office. In this SLP's opinion, this timeline adjustment made getting annual consent from parents easier, resulted in more informed consent, allowed parents to participate in the assessment process, and enabled intervention services to be provided earlier in the school year. Other SLPs who had served the same school populations for several years adjusted the timeline to do more assessing and reviewing at the end of the school year, in the months of May and June, which allowed them to determine which students would require intervention prior to the start of the next school year. They were then able to delegate intervention tasks to assistants more quickly in September and they had more time available to see new referrals.

Official Canadian and American publications did not provide any insight into the expected timeline for service provision across the school year. The most comprehensive source identified on speech-language service delivery in public schools, *Making a Difference for America's Children: Speech-Language Pathologists in Public Schools* (Moore-Brown & Montgomery, 2001), described different types of service delivery models, SLP activities, and scheduling methods but did not portray the type of timeline described by and observed in the practice of my study's participants.

Definition of Direct Service

The second understanding that informed how participating SLPs conducted their client-focused activities was their definition of direct service. The majority of the participants indicated that *direct service* referred to intervention provided to individual students or groups of students by SLPs or by support personnel. Their definition appeared to have been influenced by how statistics were collected for the Alberta government Ministry of Health and Wellness. The participants noted that the support personnel who were employed by the health region completed statistics for the government health ministry in which they indicated their intervention services as direct while for those same student cases, the SLPs indicated their supervision services as consulting.

Only 2 of the 14 SLPs participating in the study specifically separated out intervention they provided from that provided by assistants, reserving the use of the term direct for their intervention provision. It appeared that these two SLPs had retained a personal definition of "direct service" that differed from the institutional definition represented in the collection requirements for health ministry statistics. It was this personal definition which was supported by the professional literature where services provided by support personnel are considered to be indirect (Moore-Brown & Montgomery, 2001).

Some observers might protest that how SLPs refer to a service matters less than what is actually provided to individual students. I would argue that terminology used represents how concepts are organized for individuals and therefore influences the service provided. The fact that the majority of participating SLPs used a definition of direct service that included intervention by support personnel suggested that the use of support personnel as intervention providers was well established in the service delivery context. The observation that most participants spent significant amounts of time supervising support personnel often to the point of limiting their ability to provide other client-focused activities supported the predominance of support personnel in the service delivery context. This situation has been discussed in later in this chapter in Shared Focus Activities – Working with Assistants. It appeared then that considering as direct, both services provided by SLPs and services provided by support personnel, was quite possibly related to an increasing interchangeability of service providers within the health region. This hypothesis was investigated in the second stage of the study and will be addressed in the following chapter on contextual influences on practice.

Service-Focused Component

Activities and understandings designated as service-focused related to the organization of the speech-language service whether on the scale of that provided by individual SLPs, from an office site, or across the region. Within the service-focused component of participating SLPs' practiced role, seventeen different activities were clustered into three categories. In a similar manner, eight understandings were clustered into three categories.

Activities

During analysis and interpretation of the data, activities which were related to the service provided by individual SLPs were grouped together as were activities related to the service provided from their office sites. A final grouping was made up of activities related to the service provided throughout the health region. After explaining these activity groupings, I have provided a discussion of the support for these activities in the professional literature.

Relating to Services Provided by Individual SLPs

All participating SLPs were observed completing a variety of activities which helped them provide services to the caseloads at the schools allocated to them. Two of the activities, Scheduling the Service and Working with Assistants, were also client-focused, and have been discussed in a following section, Shared Focus Activities. The remaining four activities, *Managing FTE*, *Managing the Caseload*, *Learning*, and *Fostering School Relationships* will be discussed below.

Managing FTE. All participating SLPs were engaged in an activity labeled as Managing FTE which consisted of tasks involved in managing the work hours or full-time equivalent (FTE) allocated to their positions, such as working extra hours or seeking efficiencies in travel to work sites. Participants attempted to keep closely to their allocation. For example, the eight SLPs who worked part-time in schools and part-time in clinic with preschool populations carefully monitored how much time they spent on school service activities and tried to contain school-related time to the FTE allocated. Four of these SLPs specifically mentioned a perception that the heavy demands of a school caseload could easily encroach on the provision of preschool services. Participants tracked extra hours worked and arranged to take those hours as time in lieu. For example, two of the participating SLPs described adding time to their work days to accommodate the time required to travel to school sites (i.e., beginning to travel at 8 am in order to get to a school for 9 am even though they were only required to start work at 8:30 am) and taking this time off during school holiday periods.

Managing the caseload. Another significant service-focused activity was Managing the Caseload. All participants completed this activity and all affirmed the following component tasks:

1. Setting up and maintaining a personal organization system
2. Prioritizing own activities
    a. Executing priority agreements between school boards and health region
    b. Considering individual student profiles
    c. "Getting assistants up and running"
    d. Considering priorities of schools
    e. Finding time for supervision of assistants

3. Keeping track of clients
4. Monitoring numbers (using health region quota system)
5. Allocating time (also relates to scheduling the service)
6. Reflecting on client-focused activities
7. Providing information to upper management

Observations of participating SLPs underlined the importance of setting up and maintaining a personal system for organizing and tracking the copious amounts of paperwork and scheduling information required to work effectively with caseloads distributed at up to 8 different schools per SLP. The task of prioritizing their activities was also critical. To manage their caseloads participating SLPs implemented management techniques established as health region policies and procedures including eligibility guidelines, a priority rating system, a service cap, and a quota system (for more information on significant policies and procedures refer to Local Health Region – Policies and Practices in the following chapter). Participating SLPs spent time engaged in scheduling activities, maintaining waiting lists, keeping track of the status of each student, and monitoring their caseload numbers. They were also observed providing information about caseload size and workload to the regional manager of speech-language services. When questioned about this, it became apparent that the participating SLPs did not consider this task to be advocating for their clients. They seemed to view the provision of caseload-workload information to management as simply a routine task to be completed on a regular basis.

Within caseload management, participating SLPs reflected on their client-focused activities and determined when and how to adjust the overall service they provided. Interestingly, in this reflection the participating SLPs were not observed to focus on the scientific evidence base for their practice. When questioned at the second interview about how they determined their practices, the participants spoke of the benefits of experience, or finding out what worked through trial-and-error. In terms of what practices they tried, most participants discussed being influenced by informal methods such as reading reports from other SLPs, talking with other SLPs, and observing assistants trained by other SLPs. Three of the participants described the influence of professional development activities, while only two participants mentioned the influence of university training. Two participants mentioned reading literature but in one case it was unclear whether the literature referred to was research literature or test and material catalogues. Factors considered by participants in selecting tests were comprehensiveness, time to complete, availability, portability, child-friendliness, the extent to which the test assisted with the development of goals and recommendations, and the usefulness of the information to families and school teams. One participant commented that SLP test selection had been influenced by the special education funding guidelines of the Alberta education ministry. The participant stated that percentile rank scores were required for funding so tests providing those types of scores had become preferred for use with the school-age population. In selecting treatment materials, factors considered included portability, child-friendliness, efficiency, and appropriateness for use by support personnel.

Learning. All participating SLPs were also engaged in various types of learning activities that helped them provide services. While not all participants were engaged in all tasks identified under Learning, at least one participant was observed or discussed engaging in each task. All participants affirmed the following tasks as appropriate for inclusion under the Learning activity:

1. Learning about content areas, such as:
    a. Dyslexia
    b. Oral-motor activities
    c. Apraxia
2. Learning about school community demographics
3. Learning about school programs, including:
    a. Regular education
    b. Special education
    c. Services
    d. Funding
4. Practicing new skills to mastery
5. Learning new ways of doing things, such as:
    a. Organizational policies and procedures
    b. Supervision
    c. Caseload management strategies

Learning activities addressed speech-language pathology content areas such as dyslexia, oral-motor activities for students, and apraxia. In addition, learning to understand the demographics of the school communities served and to understand the school programs, both regular education and services and funding for special need students, was documented. In fact, an understanding of the special education process, especially program funding, was highlighted by participating SLPs when they were asked to select a key understanding for SLPs serving school-age children. Participating SLPs also practiced new clinical skills learned by observing other SLPs or through attendance at professional development sessions until they had mastered those skills. They were engaged in learning what they termed "new ways of doing things" whether these new ways related to health region policies and procedures or to professional information on such issues as supervision and caseload management. This activity was an aspect of practice which was consistent with their perceived ideal practice although all participants identified a need for more time for this activity as a whole and more time specifically for learning about speech-language pathology content areas and clinical skills.

Fostering school relationships. Finally, all participating SLPs were engaged in fostering relationships within the schools. While not all participants were engaged in all tasks identified under Fostering School Relationships, at least one participant was observed or discussed engaging in each tasks. All participants affirmed the following tasks as appropriate for inclusion under the Fostering School Relationships activity:

1. Supporting school fundraising
2. Being available during P/T interviews
3. Being available during teacher break times
4. Doing presentations
5. Attending formal and informal meetings
6. Team-teaching
7. Knowing names of staff

All participants held the view that these activities increased the goodwill of school staff members towards the SLP, making them more supportive of the speech-language program and more willing to facilitate it. While this view was certainly rational and somewhat supported by anecdotal evidence, the activities described were quite informal, however, and raised the question of whether more formal activities would result in more tangible benefits. While the activities participants did accomplish related to their ideal of working with school staff to assist their students, they all described having little time to complete even the informal activities identified and no time to further develop these activities.

Comparison with the literature. The majority of the service-focused activities related to the practice of individual SLPs were at least partially reflected in the literature. Ways to manage caseloads are a common topic in the literature but these discussions have largely failed to portray the complexity of the considerations made by front-line SLPs in Canada and the mix of personal, professional, and employer influences on caseload management which were obvious in this study. Most seminal practice texts urge SLPs to continue learning about the content areas and practicing new skills to mastery. Moore-Brown and Montgomery (2001) called for school-based SLPs to learn as much as they could about school programs and student populations. However, the practice literature has not emphasized the significant learning involved for front-line SLPs to adopt new ways of doing things. In terms of fostering school relationships, texts describing school practice have discussed the need to develop relationships with school staff members (e.g., Moore-Brown & Montgomery, 2001). However, as in their discussion of the ideal role, the majority of relationship-fostering strategies mentioned by participants were informal. The literature supported more formalized collaborations (Peshey & Rapking, 2003).

The participant tasks within the activity Managing FTE were not reflected in the practice literature or in the official practice documents. This omission could have arisen because the majority of the professional literature reviewed originated in the United States where most SLPs serving school-age children serve that population exclusively, may also serve only one or two schools, and are under salary contracts similar to teachers where work hours are not strictly defined. In terms of the official practice documents, it is possible that this type of activity was assumed as part of any employment situation and not specific to professional practice. In my study, however, the tasks involved in Managing FTE were a significant daily concern for participants and directly affected how and when they provided speech-language services.

Relating to Services Provided From Their Office Sites and Within the Entire Health Region

All participating SLPs completed activities which contributed to service delivery from their office sites and within the entire health region. While not all participants were engaged in all activities identified within these groupings, at least one participant was observed or discussed engaging in each activity and task. All participants affirmed the activities and corresponding tasks as appropriate for inclusion.

Services from office sites. Participants affirmed the following activities and tasks as relating to speech-language services provided from their office sites:

1. Participating in site planning
    a. Monitoring adequacy of tests and materials
    b. Facilitating ordering of tests and materials
    c. Contributing to discussion of time allocations
    d. Transitioning caseloads from preschool to school services
2. Participating in site-base initiatives (sometimes completed), such as:
    a. Improving identification of children in community
3. Fostering office relationships
    a. Meeting learning needs together (sometimes completed)
    b. Participating in office 'celebrations' and clubs – birthdays, babies, social clubs (sometimes completed)
    c. Participating in joint planning with other SLPs (sometimes completed)
    d. Maintaining regular informal contact with other SLPs
    e. Discussing cases with other SLPs
    f. Participating in specific team-building activities (sometimes completed)

Two of the fourteen participating SLPs were the only SLPs employed at their office sites. In these two cases, the site planning activities described in this section were completed by the SLP alone or in discussion with the health region manager or team leader for speech-language services. These SLPs focused on fostering relationships with other professionals situated at their offices and also spoke of the need to develop relationships with off-site SLP colleagues for support via email or telephone.

Services across health region. Participants affirmed the following activities and tasks as relating to speech-language services provided across the health region:

1. Completing paperwork
    a. Completing stats
    b. Maintaining work records
    c. Conducting performance appraisals on support personnel
2. Supervising both SLP and SLP assistant practicum students
3. Traveling to meetings
4. Participating in planning meetings
    a. Group meetings
    b. Knowing names and recognizing faces
    c. Regional meetings
5. Participating in research
6. Completing special projects at management request
7. Explaining the service to others, including school administrators and parents
8. Sharing information about service issues with management

While the time participants allocated to these activities was not recorded, it did appear to be significant. More specific information about the benefits of these activities would be useful for justifying the participation of front-line SLPs. Anecdotal reports suggested that participation in these types of activities could increase the job satisfaction of front-line SLPs. Due to the nature of these activities, many were administratively controlled by health region management. As a result, several of these activities have received further consideration in the following chapter on the organizational and governmental context of practice.

Comparison with the literature. The activities participants undertook related to facilitating the services provided from their office sites and across the entire health region were not recognized in the literature. The standards and guidelines documents available from the Canadian and American professional associations did not address activities with a site-based or organization-based focus. In a chapter on the work world of American SLPs in public schools, Moore-Brown and Montgomery (2001) provided information on such issues as securing a position, organizational structures, teacher unions, and sources of continuing education but did not describe SLPs participating in office site- and organization-focused activities. Given the significant amounts of time spent by participating SLPs on these activities, they appeared to be a glaring omission in the literature.

Understandings

During the analysis and interpretation of the work process data, understandings that informed how the participating SLPs addressed service organization were grouped into three areas. Some understandings were related to professional management, some to the provincial and local education systems, and others to social factors. The three groupings are presented below along with the relevant literature support for each.

Professional Management

Like any profession, speech-language pathology has developed certain concepts addressing how services are managed. Two of these concepts, *caseload* and *service delivery model*, were specifically addressed in this study. A discussion of participants' understandings of these concepts along with a comparison with the literature has been provided below.

Caseload. Observation and discussion with participating SLPs revealed that 13 of the 14 participants defined their caseload as the number of open speech-language files for students at the schools they were responsible for serving. They therefore included all students who had been referred but not discharged, regardless of whether they were waiting for a first assessment, receiving treatment, or waiting for treatment. One participant seemed to sum up the thinking of this group with the comment, "If they're in my filing cabinet, they're on caseload" (S3-R-SP-S Int 1 LN 2428). Caseload estimates for full-time school-based SLPs who defined caseload in this way ranged from 125-200 students. The one exception was a part-time school-based SLP who was in the process of developing a caseload of previously under-served middle school students as part of a new initiative in urban area 1 and, as a result, had a significantly smaller caseload at the time of the study. While participants who defined caseload as open files acknowledged that students within these overall caseloads would not all have the same status (e.g., waiting for assessment, assessment, treatment, and waiting for treatment), they included all of these cases in their total caseload because they were involved with each case to some extent. For example, one SLP reported difficulty considering students on the assessment waiting list as inactive files because of the need to consult with school personnel to determine the order in which assessments would occur. Because of this consultation process, the SLP had to be aware of these cases and prepared to provide a judgement on their priority (S12 U2-SP-T Int 1 LN 310-317).

One of the participating SLPs defined caseload differently. This participant focused on the status categories of active treatment, awaiting assessment, awaiting treatment, consult, and review and reported that students waiting for services, whether for assessment or for treatment, would not be included in the overall caseload number. This SLP described students who were waiting as having made it "to the worry" group but not to the caseload (S4 R-SP-S Int 1 LN 840).

Interestingly, only one of the participating SLPs did not readily identify with the idea of an overall caseload. This SLP agreed that caseload represented the total number of open files for the purposes of reporting to management and to external individuals and organizations, but appeared to use a different definition in daily practice. While conducting assessments at the beginning of the school year the participant said, "I think I take it day by day and I have a maximum of eight but comfortably seven slots in a day so that's about 35-40 a week. That's the kids that I see. There's a bunch of kids waiting" (S13 U2-SO-T Int 1 LN 507-511). Although the current status of each student who had been referred was recorded in a computerized database, the participant was unaware of the total number of cases within the database until questioned by the researcher. In contrast, it was evident from the remarks and observations of the other 13 participants that they were quite aware of the total number of open files they were responsible for, whether or not they included each file as part of their caseloads.

Reviewing the literature, my study, as best as can be ascertained, is the first investigation of how Canadian SLPs defined caseload in practice. Because the term was inconsistently used in the literature, I had anticipated more confusion among participants and was somewhat surprised to find that the majority defined caseload in the same way; as the number of open files not necessarily the number of students seen. Unfortunately, their definition did not appear consistent with that implied by the questions in the most recent investigation of Canadian caseloads, CASLPA's 2003 *Caseload Guidelines Survey*

(CASLPA, 2003) which seemed to focus on the number of students seen. However, the fact that the participants agreed on a definition that actualized to an easily obtained and verified number provided hope that more consistent and accurate Canadian statistics could be obtained in the future. The estimated caseload range of 125-200 students for participating SLPs working full-time with school-age children was not entirely surprising based on some of the higher estimates in the Canadian literature (e.g., Dohan & Schulz, 1999) and also supported the assertion that Canadian SLPs serving school-age children carried caseloads significantly higher than fellow SLPs working with other age groups (CASLPA, 2003) and also significantly higher than American SLPs working with school-age children.

Service delivery model. Without exception each participant displayed some understanding of the professional discourse on service delivery models. However, participants described their own service delivery models in a wide variety of ways despite the fact that they were each observed to be providing the same range of services in the schools in similar ways. Five of the participating SLPs termed their service delivery to be a mix of direct and consultative. One labeled the consultative component *assistant-based service delivery*, while another concurred with the mix of direct and consultative but added collaboration as a separate component. One SLP who provided treatment services only through assistants decided to term all service delivery as consultative, mentioning that in the American practice literature the label direct was reserved for SLPs providing treatment, not assistants. In contrast another SLP decided to term all service delivery as direct, considering that both SLP and assistant-provided treatment was direct. Participants seemed uncertain about descriptors appropriate for use in describing service delivery models, seeking reassurance from the researcher that descriptors such as *pull-out* and *functional* were appropriate. Five of the SLPs argued that they could not provide one single label for their service delivery model but preferred to specify what they considered as components of the model. The label "needs-based service delivery" was coined by one SLP to capture a range of service delivery activities including home program, consultation, SLP assistant treatment, direct SLP treatment, group SLP treatment, and parent training (S3 R-SP-S Int 1 LN 2361-2382).

From the observations and initial discussions with the participating SLPs, it did not appear that they had developed a concept of an "education model" for speech-language service delivery similar to that in the literature. To explore this idea more fully, at the second interview I proposed to participants the idea of a spectrum of speech-language service alignment with education, ranging from SLPs who viewed schools simply as a site for services, as exemplified in the comment "that's where school-age children are during the work day", to SLPs who viewed schools as a critical context for school-age children and carefully considered that context in service provision, as exemplified by becoming involved in school-wide initiatives and curriculum development and modification. All of the participating SLPs identified with the proposed spectrum and were readily able to describe where their current practice and their ideal practice would fall.

Three participants placed their practice more on the end of the schools being a convenient site for services. One of these participants said, "That's why I'm not a great SLP in the schools. I think some school-age children would be better served out of the schools" (S3 R-SP-S Int 2 LN 750) and went on to offer the perspective that articulation, grammar, and fluency issues might be better addressed in clinic. Another stated, "We're a very separate entity. I go into the schools. I do my work and leave" (S10 U1-SO-T Int 2 LN 203) but went on to note that ideal SLP practice would be far more collaborative. The third participant stated, "I don't think I am aligned with what's going on in the schools. I think I drop in when I have time and I do what I have time for which isn't enough" (S13 U2-SO-T Int 2 LN 834) and also went on to state that ideally, SLP practice would be more aligned with the work of schools. Therefore, even though three SLPs placed their current practice on the low end of alignment with education, two of the three were not satisfied with the level of alignment in their practice, reporting that more alignment with education would be ideal.

Seven of the fourteen SLPs described their current practice as falling in the middle of the spectrum. Three of these participants identified some perceived advantages of not becoming entirely aligned with education. Describing schools as sometimes driven by budgeting and money issues not necessarily what was best for students, one SLP offered the view that retaining a health perspective resulted in advocacy for those students whose needs did not fit within the current special education funding framework. Two of the three SLPs spoke of the need to balance school priorities with the wishes of parents when providing services. One SLP expressed a fear that total alignment with education would mean focusing "on just the kids that are *their* priorities" described as meaning that the focus would be on children with learning disabilities to the exclusion of children with speech needs and social communication deficits (S6 R-SO-T Int 2 LN 460). Participants also identified some barriers to further aligning their practice with education. Perceived barriers included attitudes of school administrators, lack of SLP time, lack of teacher time, insufficient funding, lack of government recognition of the SLP role in learning and education, and a SLP role as consultant instead of direct service provider.

Finally, four SLPs placed their practice more on the end of schools being a critical context for school-age children. One of these SLPs had been employed by an education authority in the past but reported that leadership was a more important facilitator of aligned SLP practice than employer, stating "the telling thing is the leadership and not your paycheque. The leadership, whoever it is, has to understand the school setting and be able to work cooperatively with them because we did have times when it was quite adversarial and the front-line people suffered for it" (S4 R-SP-S Int 2 LN 590). Another commented that teacher support was critical to accomplish many speech-language goals. Lack of time was mentioned as a barrier to full alignment with education. Two of the participants noted how much time both SLPs and teachers would need to plan joint interventions. One also specified that support from school administrations and government awareness of the role of SLPs in language and learning was critical.

The confusion about generic service delivery model terms evidenced in the discussions with participating SLPs had been anticipated based on the literature review as had participants' reported use of a combination of service delivery models. It was interesting to note that most participants presented as almost apologetic about what they perceived as an inability to succinctly describe their service delivery model. The participant who had coined a personal term for the range of service delivery activities she provided appeared to be most confident in describing her service delivery model. The literature concept of an "education model' (Soutar-Hynes, 1996) was not entirely supported by the stage one results, at least not in the sense of "education-focused' services being tied to the employment of SLPs by educational authorities. Instead, even though they were all employed by a health organization, participants supported the idea of a spectrum of speech-language service alignment with education with the level of support for close alignment with education varying across participants. The level of alignment with education supported by participants did influence their front-line service delivery practices. Those who valued greater alignment with education placed more emphasis on collaborative services, classroom-based services, and consultation services benefiting the entire student populations. Interestingly, although none of the participants reported satisfaction with the level of alignment with education in their practice, some perceived advantages of retaining what one termed as autonomy in the education setting. For these participants there did appear to be a tension between the speech-language priorities of a SLP and the education system-influenced priorities of an educator. This tension was explored further in stage two of the study and is discussed in the following chapter.

Education Systems

In their work, participating SLPs utilized various understandings of the education systems of the students they served. These understandings related to regular education programs, special education programs, Alberta Education coding and funding, and educational expectations for school-age children.

Regular education programs. All participants considered regular education programs when determining their assessment and intervention practices. For example, one SLP was observed administering a phonological awareness assessment to a grade one student with a diagnosed speech delay (S14 U2-SO-T Field Notes LN 159-163). The SLP reported awareness of the Balanced Literacy program used in the student's classroom and expressed the view that the program's phonological awareness component was not sufficiently intense for students with very limited skills. Because of this, the SLP offered additional phonological awareness training to needy students on the speech-language caseload. Participating SLPs also benefited from an understanding of the reading intervention programs available in each school jurisdiction. In some schools, reading intervention programs were less available and as a result SLPs sometimes became more involved with providing literacy interventions. In one case, the school-based assistant assigned to the SLP was also the early literacy assistant for part of the workday so with the SLP's direction could help students receiving both programs generalize their new speech-language skills to their reading.

Special education programs. All participating SLPs also needed to understand the special education programs offered within each school jurisdiction. When segregated programs were developed to serve particular types of students, they needed to know which types of students were eligible, considering such factors as diagnosis and severity, in order to help school teams identify appropriate students and so that they could anticipate the needs of the students and the consultation services required. At the time of my study, many schools in the health region were developing pre-kindergarten programs. These preschool programs were designed to serve three- and four-year-old children who qualified for mild-moderate and severe special education funding from the Alberta education ministry. Many programs also enrolled typically-developing children who paid fees to attend. The programs were set up in classrooms within schools served by some of the participating SLPs. At the administrative level, an arrangement had been made that school SLPs would provide consultation to the pre-kindergarten programs in their allocated schools but the individual children with mild-moderate needs would continue to receive speech-language services at the health region's preschool clinics. Three- and four-year-olds with severe needs were typically served by private practice SLPs because these children qualified for additional education ministry funding. Because of this defined consultation role, the participating SLPs who served schools with pre-kindergarten programs needed to have background information on how each program was designed. They obtained, through classroom observation, some understanding of such elements as the language stimulation skills of the preschool teachers and assistants and the overall classroom dynamics.

Participating SLPs found it useful to be aware of the availability of dedicated special education teachers in the schools. The availability of these personnel varied greatly across school sites even within the same school jurisdiction. Their roles also differed. In some schools, special education personnel taught in special education classrooms and SLPs consulted with them as they did with the regular education teachers. In other schools, special education personnel were more involved in conducting education assessments, leading the individualized program plan development process, and organizing services for students. In these cases, the SLPs were often more involved in consulting with these teachers about students on their caseloads.

Alberta Education coding and funding. In addition to understanding the regular and special education programs offered in their designated schools, participating SLPs had to understand the provincial education ministry's special education coding and funding procedures. In Alberta, special education codes had been developed to describe certain disability categories considered to have a significant effect on learning. Different levels and types of special education funding were attached to the codes. Participating SLPs were observed applying knowledge of the code categories defined by the ministry, eligibility requirements, and determining if and how funding was attached to codes. They used this information when prioritizing students for assessment, determining assessment techniques, writing assessment reports, determining eligibility for health region services, discussing services with school administrators, and advocating for diagnosed students within the school system. More information about how the practice of front-line SLPs was influenced by the policies of the provincial education ministry is provided in the following chapter.

Expectations for school-age children. Finally, participating SLPs exhibited an understanding of school-age children as a target population for speech-language services. Their assessment and intervention practices were informed by an understanding of developmental expectations, not just for speech and language skills, but also for fine motor, socialization, and academics. While understanding the importance of early intervention in the younger grades, they also recognized the needs of older students at the middle and high school levels. In the words of one participant, "I've had some speech paths say, 'Why are we still seeing middle school kids?' and I probably wouldn't have known either until I looked at the files but, for instance, one girl had a head injury from a motor vehicle accident, another just had a cochlear implant a year ago, and then there are the long-term special needs kids" (S8 U1-SP-T Int 1 LN 287-309). Another SLP noted that sometimes middle and high school students were referred because their needs had not been recognized earlier because of frequent school switching or because higher academic demands made their language difficulties more evident (S11 U2-SP-T Int 2 LN 206-230).

Comparison with the literature. Participants showed additional support for education-focused speech-language services in their emphasis on understanding the education systems their clients were enrolled in. All participants recognized the need to understand both regular and special education programs and the characteristics of the school-age population in order to best provide speech-language services within that context. Indeed, despite their employment in health, their emphasis on understanding the education systems was similar to that recommended in the American literature for school-based SLPs (ASHA, 1999; Moore-Brown & Montgomery, 2001) and in Canada by Soutar-Hynes (1986).

Social Factors

In addition to professional management and education system understandings, participating SLPs showed understanding of the influence of social factors on their practice. They were particularly aware of the importance of building and maintaining relationships and of considering the relevant characteristics of student populations in different school communities.

Importance of building and maintaining relationships. Previously, activities were described which demonstrated how participating SLPs built and maintained relationships with both school staff members and with other service providers in their local offices. Their participation in these activities was based on their awareness of the importance of working as a team. For example, they acknowledged that their ability to provide effective speech-language service delivery to school-age children depended on establishing and maintaining open lines of communication with school staff members. In the words of one participant: "No matter how good the staff you've got, no matter how good the ideas you've got, you may find that there's not an openness that you need to be able to do that good work with those good people." (S14 U2-SPT Int 1 LN 2245-2250). Participants were observed working with classroom teachers, special education teachers, and with other rehabilitation professionals. Participants were also aware of the influence that school administrators could have on their own front-line activities and comfort in their schools. School administrators were recognized as setting the tone for SLPs' interactions with staff members. Participants understood that if they had a positive and supportive relationship with the school administrators, service delivery at the school became easier for all concerned. Their actions to foster relationships with school staff members were based on these understandings.

Importance of considering student populations. When planning and providing services, participating SLPs considered relevant characteristics of the student populations within different school communities. They recognized a link between lower socio-economic status (SES) and language needs, anticipating more language development cases at schools in lower socio-economic areas. Participants also linked lower SES with transiency, recognizing a need to track students as they moved between schools within the health region and transfer files between SLPs. They considered SES when planning intervention programs, acknowledging that parents who were working several low-paying shift work jobs would not be as available to assist with homework. Cultural differences were also considered as in the case of SLPs who served schools with significant aboriginal populations. In the rural areas, SLPs were cognizant of the weak farm economy and accompanying stress on their students' families. For example, one SLP spoke of being hesitant to recommend dental treatment for a student with a lisp, knowing that the student's farm family would have no dental insurance (S4 R-SP-S Int 1 LN 735-743).

Comparison with the literature. The emphasis placed by participants on understanding the social factors impinging on their ability to provide services was supported by the literature (Blosser & Neidecker, 2002; Moore-Brown & Montgomery, 2001). Their understanding of the importance of relationships and the characteristics of the student populations appeared to facilitate their provision of speech-language services that were aligned with the needs of the education systems and the broader communities. However, the relationship between these understandings and subsequent actions has not been addressed in the literature.

Shared Focus Activities

During data analysis and interpretation, I discovered that two of the major activities of participating SLPs focused on both individual clients and the overall service. Tasks within these two activities, which were labeled as Scheduling the Service and

Working with Assistants, were analyzed in more detail due to this dual focus and the pervasiveness of the activities in practice.

Scheduling the Service

Through interviews and observations with participating SLPs it became apparent that significant amounts of time were spent on scheduling or time allocation tasks. These tasks were necessary for providing service to individual clients on a daily and weekly basis and for managing the overall service across longer time periods. With limited staff time available and significant numbers of clients to serve, participating SLPs carefully planned tasks and allocated their time and that of any support personnel available to them. After recording and analyzing the tasks following the first interviews and observations, I realized that participants were informally grouping the tasks according to whether they were primarily considered by school year, by treatment block, monthly, weekly, daily, or on an ad-hoc basis. This categorization and the considerations within each category were validated by participating SLPs in their second interviews.

School Year Plan

To organize the overall service, all participating SLPs developed a personal work plan for the school year at some level of formality. Participants took the following factors into account when developing these yearly plans:

1. Program planning days (health region service meetings)
2. School SLP allocation (includes FTE and schools assigned)
3. School calendar (start-end, holidays, professional development days)
4. Kindergarten and school schedules
5. Availability of space at individual schools
6. Treatment blocks
7. Health region assistant allocation
8. School-based assistant allocation
9. Group meetings

The interaction of these factors proved particularly problematic for participants. Some schools offered kindergarten on a half-day schedule while others provided Monday/Wednesday or Tuesday/Thursday full day programs. Because of the demands for speech-language services at the kindergarten level, when kindergarten students were available at particular schools was often a prime consideration in establishing the SLP schedule. However, many schools had few appropriate spaces available for working with students one-on-one or in small groups. Some SLPs could only obtain a suitable space at a school on a set day each week. SLPs also considered if and when school-based assistant time was available. Some of the participants described difficulties accommodating cyclical daily schedules at their assigned schools. For example, a SLP could schedule visits to a particular school each Tuesday but a school-based assistant might only be available on Day 2 of a four day cycle. If the SLP needed to meet with or observe the assistant on a Tuesday which was not a Day 2, problems arose unless the school team was flexible in releasing the assistant from other responsibilities and allowing students to be pulled from classrooms as needed. These scheduling conflicts were most problematic for those SLPs who also served preschoolers. They noted that they had less flexibility in their weekly schedules because they needed to keep preschool appointments at the same day and time each week in order to promote consistent attendance.

Participants also considered caseload management strategies, such as block scheduling and timing of assessments, when planning for the school year. Block scheduling is discussed in the following section. SLPs considered adjusting the timing of assessments to alleviate build-up of assessments at the beginning of the school year. One participant conducted assessments in August by having parents/guardians bring clients to the office and another did August assessments at a year-round special needs school. More commonly participants attempted to conduct new assessments and reviews throughout the school year whenever possible.

Block Plan

All participants had either established or anticipated establishing treatment blocks to address their caseloads. To establish treatment blocs, they typically considered the timing of the blocks when making up their school year plans. Sometimes block scheduling was determined after spending a period of time doing assessments and reviews at the beginning of the year. For SLPs utilizing treatment blocks, block scheduling provided an interim focus between school year and monthly plans. Participants determined the number of weeks in a treatment block by the time available between school holidays and set specific start and end dates according to school calendars. Established treatment blocks thus provided sub-units of time for certain activities to be accomplished. Some SLPs established one set of treatment blocks for assistants and another for themselves. Block scheduling was sometimes utilized when there was uncertainty about the availability of a particular assistant across the school year. For example, one SLP established a fall treatment block for an assistant because of uncertainty about the assistant's school allocation for the second half of the school year.

One SLP used block scheduling as part of what she termed a "triage system". This participant had traditionally established three treatment blocks per school year – September to December, January to March, and April to June with assessments and reviews conducted at the office in the summer months whenever possible. In each block a spot was kept open for consults or intakes. These were quick discussions with parents/guardians and potential clients to answer questions or concerns and to help determine the need and priority for full assessment. New assessments and necessary reviews of current clients were done towards the end of each treatment block. Direct treatment was allocated to the neediest clients on caseload at the time each block commenced. This prioritization scheme meant that some clients received consecutive blocks while others were 'bumped' off direct treatment to home programs when other needier clients came on caseload. The participant was motivated to create the block management system because of personal experience with waiting for a medical service for a child. As a result of that experience, this SLP did not want to wait long to at least consult with concerned parents and for parents to then only wait the short period of time until the end of a block to have their child considered for service. The SLP served both preschoolers and school-age children in a large but sparsely populated rural area, and described basing treatment on highest need applied equally to school-age clients and preschoolers, meaning that schools did not know if their students were going to be seen until the end of each treatment block. This participant disagreed with dividing services among schools equally based on time available and caseload sizes, preferring instead to make the needs of referred children the primary consideration (S3 R-SP-S Int 1 LN 1140). The participant emphasized that clients with mild concerns were not refused service but were provided alternatives to direct treatment such as home programs or supplemental school materials. The participant noted that ability to use the triage system depended on the cooperation of administrators at the individual schools. They had to understand and accept that the SLP was considering the needs of students across their school district not just within their schools. The participant felt that successful implementation was a testament to the sense of broader community in the rural area and a result of the fact that all the assigned schools were in the same school district so the school administrators collaborated on other issues and knew of the needs at other schools.

Monthly Plan

Participants also considered their schedules on a monthly basis. Considerations within this included:

1. Consultation
2. Service to home-schooled children
3. School calendar (days off, special activities)
4. Committee work (meetings)
5. Supervision of assistants

Scheduling consultation visits and appointments with home-schooled clients were scheduled by participants on a monthly basis. Home-schooled clients were typically seen at health unit offices after regular school hours or during office time. Some sites allocated home-schooled clients to a SLP responsible for serving preschoolers in order to facilitate the scheduling of office visits. One participant noted delegating treatment for a home-schooled client to a health region speech-language assistant and then supervising that treatment on a monthly basis. Home-schooled clients were not on the speech-language caseloads in significant numbers. Many regional sites had only a handful of home-schooled clients. Interestingly, one participant expressed concern that the incidence of speech-language delays and disorders might be higher in the home-schooled population if their parents/guardians had elected to home school because of prior issues with special education systems or in order to 'protect' a disabled child. Home-schooled clients were typically referred to speech-language services by parents or physicians and other health care providers.

For service-focused activities, participants considered the monthly calendars of upcoming events published in each school's newsletter. Being aware of these events helped them to plan their visits to assigned schools. For example, if a participant typically went to a school each Tuesday afternoon and then discovered that several grades were going to start leaving school for swimming each Tuesday afternoon, she or he might attempt to switch days with another school. Committee meetings and supervision of assistants were other service-focused activities considered on a monthly basis.

Weekly Plan

A main unit of time for participating SLPs was the work week. Factors included in scheduling their work weeks were as follows:

1. At-School Client-focused activities
    a. Intervention
    b. Assessment
    c. Consultation
2. Office Time (sometimes included)
    a. Committee work (not meetings)
    b. Scheduling
    c. Reporting
    d. Parent meetings
    e. Teacher consultations

Thirteen of the fourteen SLPs established a rotating schedule at the beginning of the school year which allowed them to visit each of their assigned schools on a regular basis, often once per week. Some SLPs used half-day blocks in which some schools with smaller caseloads received one half-day per week and other schools with larger caseloads received two half-days on different days of the week. Travel times were carefully considered when establishing a weekly schedule. One participant described attempting to provide one half-day of service each week for each of four small rural schools but revising the plan to provide full days of service every second week due to time wasted in traveling between schools.

One of the SLPs used an alternative weekly plan. This participant did not establish set days for visiting each assigned school but rather notified school administrations and assistants each week of the schedule for the following week. The SLP reported perceived advantages of the plan including improved responsiveness to school requests for assessments and to assistant requests for consultation as well as greater SLP flexibility to focus time on the priorities across the caseload rather than being tied to spending set times at particular schools.

When considering their work weeks, participants also had a sense of the intervention, assessment, and consultation activities to be conducted at each school during the upcoming week. Some of the SLPs allocated office time on a weekly basis. In that time, they would work on committee work, scheduling tasks, and reporting. These SLPs also sometimes scheduled parent meetings and teacher consultations during their weekly office time.

Daily Plan

Discussing scheduling tasks considered on a daily basis, participants noted that the daily plan was really the execution of the weekly plan in terms of the client-focused activities. Additional factors are included below:

1. Executing weekly schedule for at-school client-focused activities
2. Informal or formal recording for health region statistics
3. Charting
4. Traveling
5. Contacting teachers
6. Fitting in supervision of support personnel as needed
7. Monitoring hours of work
8. Making flexible adjustment
    a. Considering space availability at schools
    b. Considering accessibility of students

As demonstrated above, in addition to client-focused activities, participants also needed to find time for more service-focused activities such as formal and informal recording for health region statistics, charting, travel, teacher contacts, and sometimes supervision of assistants. In managing their time they considered their hours of work and the need to flexibly adjust their plans depending on the circumstances presenting at each school in terms of space availability and accessibility of students. For example, in some schools the SLP and an assistant shared the same space, meaning that if the assistant was conducting treatment the SLP would be able to conduct an assessment only if another private space could be found. In terms of accessibility of students, if a student to be assessed was ill, another student on the assessment waiting list would be substituted. If students in an early grade were unavailable due to an assembly, priority might be shifted to older students.

Ad-hoc Plan

Participating SLPs also described fitting in some activities on an ad-hoc basis. Activities falling into this category have been listed below:

1. Parent-teacher interviews
2. Summer services
3. Special projects
4. Fitting in cancelled sessions/time
5. Vacation time
6. Meetings
7. Extra consultation to wider school programs
8. Presentations (partnering opportunities)

With regard to service to individual clients, a few SLPs attempted to make up for cancelled sessions if circumstances permitted and a few acknowledged participating in parent-teacher interviews. In terms of the overall service, most SLPs provided extra consultation to wider school programs on an ad-hoc basis. Some SLPs put into place special projects in the summer. Most SLPs obtained office time on an ad-hoc basis, advising schools when they needed to stay at the office to do reports instead of coming out. One SLP found that school teams were more receptive when she brought her own laptop computer to the school and did reports there. This participant felt that her presence at the school reassured the school team that the needs of their students were indeed being addressed. Another SLP reported taking no office time in September but taking one office day per week starting in October. A rotation was established so that each school missed one day of on-site time. While some of the SLPs scheduled their vacation time as part of their yearly plans it appeared that most of them scheduled vacation time on more of an ad-hoc basis. Many chose to take their vacation time during the summer and Christmas holidays when the schools were closed. Some of the SLPs also mentioned occasionally being invited to give presentations to various community groups. Looking at these presentations as partnering opportunities they made time to do them on an ad-hoc basis. Meetings of various types were also fitted into the schedule as they arose.

Literature Support and Understandings about Scheduling the Service

Scheduling the Service was clearly a significant and time-consuming activity for participating SLPs, requiring consideration of a great number of variables and distribution of time for both client-focused and service-focused tasks. The extent and complexity of scheduling has not been acknowledged in the Canadian professional literature. Lafargue and Vowels (1985) included "scheduling" within the category of "departmental work". While the overall category took up 19% of the time available to the participating SLP, the scheduling function was not specifically described but instead lumped in with statistics, public relations, departmental meetings, committee work, administrative correspondence, and travel time.

While participants validated the differentiation of scheduling by time frame, in practice they clearly understood the significant overlap in these considerations. School year considerations influenced weekly considerations which in turn influenced daily plans. Treatment blocks influenced monthly, weekly, and daily plans. Indeed, participants recognized and acted on the need to manage all of these different scheduling considerations simultaneously. They understood this to be a significant responsibility critical to their attempts to balance competing demands on their time.

Working with Assistants

Working with Assistants was the second SLP work activity with both client-focused and service-focused components. All participating SLPs worked with support personnel to some extent. Speech-language assistants were hired by the health region and also by school districts. Some of the assistants hired by school districts were hired specifically as speech-language assistants and in most of these cases special funding from a joint health and education initiative to improve student health services financed the positions. Other assistants were hired by individual schools and the financing of the positions varied along with the extent to which the assistants were allocated to assist with speech-language services. For the purposes of this study, all assistants hired by school districts or individual schools to assist with speech-language service provision and placed under the supervision of an SLP have been referred to as "school-based speech-language assistants". This designation is consistent with how the participants themselves referred to these assistants. Thirteen of the fourteen participants directly supervised either health region or school-based speech-language assistants. The other participant had a mostly consultative role serving middle school students and worked with teaching assistants who remained under the supervision of a classroom or special education teacher.

Through interviews and observations with participating SLPs it became apparent that all invested significant amounts of time and energy to ensure that services provided to clients through assistants were appropriately delegated and supervised. It was also clear that in most cases even greater amounts of time and energy were required to plan utilization of the assistants available to participants. Several sequential and cyclical tasks were identified within the Working with Assistants activity and these tasks were validated by participants in their second interviews. Tasks included (a) planning for assistants, (b), selecting cases to delegate, (c) scheduling, (d) setting up programs, (e) supervising, (f) managing ongoing worksite caseload and (g) conducting performance appraisals. The scheduling tasks had already been addressed in the Scheduling the Service activity. Sub-tasks and considerations related to the other tasks have been described in the following sections. These sub-tasks and considerations were also affirmed by all participants as appropriate for inclusion. While not all participants engaged in all the sub-tasks or considerations, at least one participant was observed to or discussed engaging in each in each sub-task or consideration.

Planning for Assistants

Sub-tasks related to planning for assistants validated by participating SLPs included:

1. Organizing assistant time
    a. Working with other SLPs to plan for use of health region assistants (sometimes completed)
    b. Encouraging schools to provide assistants (sometimes completed)
2. Reviewing students
3. Assessing new referrals

These sub-tasks have been considered in details in the following sections.

Organizing assistant time. In many cases, participating SLPs had both health region and school-based assistant time available to them. In the case of health region speech-language assistants, participants often knew at the start of the school year if and how much assistant time they would have. Sometimes, due to staffing uncertainty, decisions about assistant allocations were made only for the first half of the school year. All but three of the fourteen participants worked with health region assistants on a regular basis. Two who did not were both part-time clinicians with smaller caseloads while one served schools who provided sufficient school-based assistant time. In most cases, participants worked with other SLPs at their sites or neighboring sites to determine which days of each assistant's work week each SLP would be responsible for planning and supervising.

Seven of the fourteen participating SLPs were directly supervising school-based assistants at the time of the study, meaning that they had each been allocated a specific amount of school-based assistant time for delegating speech-language treatment activities. The other seven were all involved with school-based assistants in terms of providing recommendations to classroom teachers who then utilized school-based assistants to carry out those recommendations but did not have school-based assistant time directly allocated to them. In some cases, SLPs receiving school-based assistant time knew of the time allocations prior to the school year because the assistant time was funded through an ongoing joint education-health initiative. In most cases, SLPs received school-based assistant time according to student need at particular schools, in which case allocations were determined as individual students were assessed by the SLP or as it became evident that a group of students qualified for special education funding. Three participants who came to these arrangements with school administrators reported a responsibility to advocate for more school-based assistant time for newly assessed students and to comment on the benefits of the arrangements on a regular basis.

Reviewing students and assessing new referrals. Although the need to review students and assess new referrals existed regardless of the necessity of planning for assistants, the timing was heavily influenced by the presence of assistants. Most participants reported a time crunch at the beginning of the year during which they focused on reviewing clients as quickly as possible in order to "get the assistants up and running". They felt a significant responsibility to delegate treatment to any available assistants in order to utilize as much of the available time possible for the benefit of clients. In many cases, the SLPs attempted to sort through their overall caseloads to quickly estimate which students would require treatment that could appropriately be delegated to assistants and reviewed those students first. Assessments of new referrals were fit into these considerations with the potential appropriateness of delegating the case to an assistant a consideration in the timing.

Selecting Cases to Delegate

Speech-language assistants are not considered to have their own caseloads but to assist SLPs with theirs. Participants who worked with assistants therefore selected a set of cases to delegate to each. For most SLPs this was a gradual process occurring on a case-by-case basis as they completed reviews. Some participants considered all the students they knew needed treatment at each school at a particular point in time and chose cases to delegate from this pool. Regardless of the timing, in selecting cases for assistants, SLPs discussed and/or were observed making the following considerations:

1. Client (student) considerations, including:
    a. Diagnosis
    b. Severity
    c. Previously on Alberta Education-funded preschool program
    d. Age/Grade of student
    e. Impact on intelligibility
    f. Prognosis
    g. Ability to benefit at this time
    h. Priority rating scale provided by health region
2. Provider considerations, including:
    a. Experience of assistant
    b. Availability of assistant
    c. Availability of SLP
    d. Frequency of service required
    e. Comfort levels of assistant and SLP
    f. Need for classroom contact
    g. SLP's previous experience with student
    h. Assistant's relationships with parents

3. Wishes of school staff
4. Wishes of parents

These considerations have been considered in detail in the following sections.

Client (student) considerations. This set of considerations included such factors as a student's age and grade, diagnosis, severity, and prognosis. Priority for service was generally given to younger students. Diagnosis, severity, and prognosis required more deliberation. Related considerations included the impact of the difficulty on the intelligibility of the student's speech in the case of speech delays and disorders and whether the student was transitioning from preschool special education services at the start of grade one. The client had to present with a significant difficulty that the SLP was confident could be effectively and efficiently treated by an assistant. Some SLPs also considered the behavior of clients when making this judgment, avoiding delegating clients with significant behavioral issues. Provider considerations therefore prevented decision-making from being based entirely on client needs. Interestingly, only one participant clearly referenced the priority rating scale provided by the health region. As an example of an organizational policy and practice influencing front-line work, this priority rating scale has been further considered in the following chapter.

Provider considerations. Considerations related to the service providers included the comfort levels of both the SLP in delegating a particular type of case and of the assistant in working with that type of case. The experience of the assistant was a factor. Provider availability was a significant consideration for all participants. The availability of assistants did not always coincide with the availability of students. For example, a SLP might only have access to an assistant on Tuesdays and Thursdays while a particular student might attend Monday/Wednesday kindergarten. Participants also weighed their own availability when selecting cases for assistants. Some participants were not able to provide direct treatment themselves due to the numbers of assistants they supervised. In these cases, if a student needed treatment the SLP found a way to delegate that treatment to an assistant. Other participants found time to provide some direct service. Interestingly they did not always select the most severe and complex cases to work with themselves. Sometimes, SLPs decided to delegate these cases to an assistant if the assistant was able to provide a significantly greater frequency of service. As one participant commented "that's the only option there is for more intensive service" (S14 U2-SO-T Int 1 LN 282-292). Participants accommodated by increasing supervision of the assistant in these cases.

In delegating treatment to assistants, SLPs also considered aspects of the treatment program, including optimal frequency of service and the need for collaboration with the classroom teacher. As described in the previous paragraph, frequency of service was considered when speech-language assistants were able to provide more frequent treatment than the SLPs. Sometimes SLPs felt that it was critical to provide a student with a treatment program which was tailored to classroom learning objectives. In these cases, some SLPs preferred to provide the program themselves, being of the view that it was inappropriate to expect an assistant to take on that level of responsibility. Other participants facilitated planning meetings with the classroom teacher that were attended by the assistant.

Participating SLPs also considered their own previous experience with students, sometimes using that experience to help them decide that the student's needs could indeed be addressed by an assistant and other times electing to continue working with that student themselves because of the rapport they had established. One SLP discussed considering any relationship between the assistant and the student's family. In the small community where the SLP worked, assistants with school-age children of their own were often friends with the parents of the clients. In these cases, conflict of interest and confidentiality concerns were carefully considered by the SLP.

All participants reported considering these factors when selecting cases for assistants. With the exception of prioritizing younger students, however, outcomes of SLP considerations varied depending on individual circumstances. For example, while a particular SLP might typically have delegated treatment for a kindergarten student with moderate phonological delay to an assistant, provider considerations such as an inexperienced assistant might result in a decision not to delegate the case. However, other SLPs faced with similar situations but unable to provide consistent treatment themselves might still delegate the case to an inexperienced assistant but attempt to increase the specificity of the program and the amount of supervision provided.

In an interesting anomaly, one participant reported involving a health region assistant in the review process (S2 R-SP-T Int 1 LN 527-539). They went out to schools together and the assistant observed the SLP reviewing the children. They then discussed the cases and how they could best be addressed within the available staff time. The appropriateness of involving a support person in this type of activity could be further investigated in the future. While the participant reported that the assistant gained a greater understanding of the children's needs and that was likely the case, there was no evidence to support the assertion. For the activity to be appropriate, the SLP would also have to retain the ultimate decision-making authority.

Setting up Programs

After participants had selected cases to delegate to their assistants, they then had to set up the programs. "Setting up" was the term used by the SLPs to refer to the specification of goals and objectives and frequency of service for each student's program, explanation of each program to the assistant, and any necessary demonstration of techniques or materials.

Supervising

Each participating SLP carefully considered the supervision of any assistants providing treatment programs under their direction. Sub-tasks under supervision including the following:

1. Meeting to go over goals and materials
2. On-site observation
3. Monitoring homework provided to students
4. Checking in/touching base
5. Mentoring or training
6. Monitoring hearing screening process ("grey area" of unspecified responsibility)

The supervision process for each delegated case typically began with a meeting to go over program goals and objectives and appropriate techniques and materials. The SLPs then scheduled regular on-site observations of the assistant working with each delegated case. These observations were the more formal part of the supervision process. Several participants mentioned trying to do formal observations at least once every 10 treatment sessions. During these observation sessions, SLPs were observed working side-by-side with assistants. The assistants would lead the students through some of the typical treatment activities and the SLPs would jump in to offer feedback and to model new techniques as appropriate. The assistants readily asked questions about particular aspects of treatment. Participants often checked on the homework being provided to students by the assistants and whether it was being completed. Typically, SLPs and assistants met for a debriefing session after seeing several cases together. These sessions often occurred at school recess times or free periods. The SLPs and assistants were observed troubleshooting issues around particular cases, planning future observations, and discussing scheduling and communication issues. In many schools assistants helped collect referral and consent forms for the SLPs. Participating SLPs typically documented on-site observations and discussions with assistants in writing. They used a variety of health region-provided and non-standard forms to do so.

In addition to on-site observations, less formal supervision occurred through what participants referred to interchangeably as "checking in" or "touching base". This task involved informal discussions with assistants about their overall workload and/or particular cases. This task was typically completed on an occasional basis between scheduled on-site observation sessions and most often occurred spontaneously when SLPs crossed paths with the health region assistants at the office or with the school-based assistants when in the schools to conduct assessments or attend meetings. Sometimes SLPs made a special point of checking in with particular assistants about certain cases that had proven challenging in some way. Most of the participants did not have much flexibility to increase the frequency of formal supervision of an assistant but they accommodated for this by informally checking in with the assistant more frequently. While SLPs were observed documenting these informal conversations in client files, they did not appear to track the frequency of these informal contacts or ensure that all cases were discussed over time.

Supervision issues seemed to arise more with school-based assistants who provided speech-language treatment services on a part-time basis along with other school-based responsibilities. Several participants noted difficulty scheduling on-site observations with these assistants. One could not change the day of the week allocated to a particular school because of preschool service commitments. As a result this participant sometimes arrived at the school on a day of the school cycle when the assistant would normally be doing other tasks. Although the school team had cooperated to free the assistant for some of the time the SLP was in the school, the resulting ad-hoc treatment sessions were often not of the typical length or presentation. They were more like informal "check-up" sessions. As a result, the SLP was concerned about not getting a complete picture and accurate of what was going on with the children (S2 R-SP-T Field Notes LN 130-134). Another participant noted having to juggle her own activities at a school to accommodate the varied schedule of a school-based assistant who saw speech-language treatment cases intermittently within her main focus on early literacy intervention.

In addition to their role in ensuring that assistants were providing appropriate treatment services to individual clients, participating SLPs also accepted broader responsibility for the work lives of assistants. This responsibility was referred to as "mentoring" by some and "training" by others. In all cases, it was apparent that the SLPs recognized their role in increasing the knowledge and skills of each assistant. The observation that assistants under the supervision of SLPs undertook hearing screenings was discussed in a previous section.

Managing Ongoing Worksite Caseload

As part of the supervision of all assistants, participants needed to manage the ongoing caseload at each worksite. This management involved being constantly aware of the characteristics and progress of each case delegated to an assistant. The SLPs considered additional delegations as necessary in order to maximize the number of students receiving treatment and also considered moving cases to other forms of treatment in order to maximize student progress or allow other needier students to receive service. They also continued to bear responsibility for communicating with school teams and parents/guardians about individual cases delegated to assistants.

Conducting Performance Appraisals

Participants conducted performance appraisals for health region speech-language assistants. A form was provided by the health region. Many SLPs also provided feedback to school administrators on the performance of school-based assistants but they did not participate in any formal performance appraisal process for these individuals. Instead, the feedback they provided was often unsolicited. Participants sought to provide feedback in order to reinforce their support for the school's funding of the assistant time (S2 R-SP-T

Int 1 LN 487-494) or to argue for replacement or retraining of a particular assistant who was having difficulty with the demands of the program (S10 U1-SO-T Int 2 LN 252-412).

Literature Support and Understandings Related to Working with Assistants

The fact that Working with Assistants was a significant activity for most participants was somewhat expected based on the review of the literature. However, during the course of this study, it became evident that contrary to the vision put forward by Hagler's research team in 1993, front-line SLPs most often supervised support personnel who had no formal training. Indeed, the formal training held by some of the assistants was considered inadequate by supervising SLPs and on-the-job training was still heavily relied upon to ensure competence. While participants' actions with support personnel did not contravene CASLPA's 2004 position statement on the use of personnel, many of the activities and considerations made by front-line SLPs in the course of working with support personnel were not addressed in the CASLPA document, particularly those that arose because of the extent of participants' involvement with school-based assistants.

In their second interviews, I entered into discussions with participants about several issues identified in the practice literature, one of which was the idea of extending speech-language services through the use of support personnel. I asked each participant to identify specific issues in the use of support personnel to extend service. I also asked them to comment on the common perception that using support personnel would increase the number of students seen in a speech-language program.

All participants reported an acceptance of the role of support personnel in assisting with speech-language service provision. This acceptance was exemplified by a participant who said "I feel we can work as a team" (S9 U1-SO-T Int 2 LN 161). Participants did however emphasize a critical need for support personnel to be both well-trained and well-supervised. Formal training programs for assistants were not seen as a panacea. Commenting on the assistant training programs available at the time of the study, S7 argued that students were not receiving enough practicum experience and required significant on-the-job training when hired as new graduates (S7 U1-SP-T Int 2 LN 372-441). S12 noted that formal training programs could be dangerous if a SLP assumed the assistant had a level of competence that was not necessarily there (S12 U2-SP-T Int 2 LN 375-523). Participants highly valued experience in working with other SLPs as part of the training of assistants. S1 noted that the effectiveness of assistants also depended on their recognition and willingness to inform their supervising SLP of issues (S1 R-SP-T Int 2 LN 2285).

Relating to training and supervision, many participants expressed specific concerns about school-based assistants. They were concerned about their lack of control over who was hired or assigned to be their assistant. S1's comments were typical: "I don't have a say in the schools and I've had some situations over the years where they got the job because they had the most seniority and they really weren't the right person. There's nothing I can do about that because it's a union issue and I think that's a danger." (S1 R-SP-T Int 2 LN 2385-2386). Turnover of school-based assistants was a significant concern because of the time SLPs would invest in on-the-job training. As S8 commented, "It can take six months to a year to really get them up to speed on their training and they might quit or have a new job by next year and then sometimes you feel like you're wasting a lot of your time training somebody who is going to get maybe partway through the year and then be gone." (S8 U1-SP-T Int 2 LN 275-278). Participants also described situations where they were not involved in determining when school-based assistants would be available to work with speech-language cases. For example, S2 noted that "the school's needs are met first then what is left over is given to the SLP and my scheduling needs are not considered." (S2 R-SP-T Int 2 LN 821).

Participants concurred that their current use of assistants increased the number of students receiving speech-language services but when questioned as to whether they would support a move to increase the use of assistants pointed out several limitations and risks. They emphasized that available time provided a limit on how many assistants a single SLP could appropriately supervise. For example, echoing the findings of this study, S1 described the number of time-consuming tasks involved with working with an assistant (S1 R-SP-T Int 2 LN 2379-2382). The desire to provide a spectrum of service to students was also argued as limiting the use of assistants. Participants noted that if the number of assistants assigned to a SLP increased to the point where the SLP only had time to do supervision, the spectrum of services would be reduced. There would be no time for ongoing assessments, consultation with teachers and parents, and treatment services inappropriate for delegation to assistants would not be available. Participants argued that as a result the quality of the overall service would be compromised.

To improve the use of assistants in speech-language services, participants stated needs in several areas. They expressed a need for school administrators and teachers to become more informed about the limitations of providing speech-language services through assistants. They wanted to prevent what S6 described as "overvaluing" of paraprofessionals as in the example of school personnel assuming that school-based assistants were capable of working without significant SLP supervision after attending a short training workshop (S6 R-SO-T Int 2 LN 490-501). They also emphasized a need for guidance within employment settings on working with assistants. S12 argued for appropriate supervision of assistants to be made part of formal SLP position descriptions and for policies around how supervision should be provided and monitoring of SLP performance in the area (S12 U2-SP-T INt 2 LN 380-413). As well, several SLPs specifically praised the health region's new practice of limiting SLPs to one assistant per school, noting that it had reduced school demands that they train many different educational assistants.

Several participants expressed concerns about their profession's clarity about its role with assistants. For example, while noting that guideline statements were available from professional associations, S3 stated, "I don't know that there is an atmosphere, in general in our profession, conducive to taking the role of supervision seriously. We need to really develop the recognition that SLPs are legally responsible for those services." (S3 R-SP-S Int 2 LN 805-807). They also argued that research was needed into the outcomes for different types of students when seen by speech-language assistants and into how treatment differed when provided by assistants versus SLPs.

Shadow Component: Environment-Focused Activities

In addition to information within the well-substantiated categories of client-focused and service-focused activities, information about additional activities that appeared to be focused on the overall environment within the school served and the broader communities was obtained during the data collection process. When these activities and tasks were presented to participants during their second interviews, however, they expressed discomfort about validating the categorization although they each admitted participating in at least one of the activities and tasks. Their discomfort appeared to be based on reluctance to "officially" accept any additional responsibilities. Because participants were either observed engaging in these activities or described these activities to the researcher, it was considered inappropriate to simply omit them from the study. The activities have therefore been described along with any available literature support.

Participants engaged in a variety of activities which all seemed to serve the function of increasing the community's awareness of speech-language pathology as a profession, the needs of people with communication disorders, and the available services. These activities included informal sharing in social situations, newspaper articles, Speech and Hearing Month promotions, and presentations to community groups. Level of participation by SLPs in these activities varied widely. For example, while all reported participating in informal social sharing, only one had written a newspaper article. Speech and Hearing Month activities and presentations to community groups were fairly common but not engaged in on a consistent basis due to other demands on the SLPs' time.

Through observations and discussions with SLPs, it became evident that their many contacts with parents and school staff were not only client and service focused but also served the purpose of educating these groups about the work of speech-language pathologists and speech-language disorders and services in general. When this view was expressed to participants, they acknowledged this "educational spin-off effect" but were not sure of its significance.

Canadian practice standards do not mention these types of awareness and education activities but CASLPA's newsletter does feature examples of these activities, suggesting that there was some level of support for them in the Canadian professional community. In contrast, American literature and practice documents highlight these types of awareness and education activities for serving prevention and identification functions (e.g., ASHA, 1999; Moore-Brown & Montgomery, 2001).

Summary and Discussion of Currently Practiced Role of Front-line SLPs

This review of the practice activities and understandings of the participating front line SLPs revealed a current role dominated by a dual focus on managing the large numbers of clients and on managing the finite staff time available to address their needs. The two themes identified within the perceived ideal role of participants were evident in their current practice. While personal and service orientation to the first theme of "doing what was best" for individual clients was observed throughout the activities and the understandings which informed them, the overall reality more closely resembled rationing of services with dubious results. This reality further demonstrated the second theme of ambiguity about their professional role as participants indeed struggled to reconcile the need for both global considerations of service delivery and considerations focused on individual clients.

As anticipated, discord between these two themes was evident in practice and revealed itself in the daily struggles of participants to manage their caseloads. Participants spent significant amounts of time, arguably their most precious resource, on caseload management and scheduling activities during which they attempted to spread service time across ever-increasing numbers of clients.

Participating SLPs were unable to achieve their perceived ideal practice. The sheer number of clients requiring service and the number of service sites appeared to largely overwhelm the service's capacity for the timely, collaborative, needs-based practice with individual clients that participants had previously promoted as their ideal. Participants were also unable to spend much time promoting supportive language-learning environments.

Indeed, the numbers and time pressures appeared to be related to an observed distancing of the SLPs from those they had wished to support – teachers and parents, and even the children they served. Personal contact seemed to lose out in the competition for time.

As an institutional response to the situation, support personnel seemed to be increasingly available to the front-line SLPs to assist them with their work. On the surface the increase in support personnel seemed to be a straightforward and sensible response to a corresponding increase in the number of clients requiring service. My analysis suggested some troubling side effects however. In many cases, the SLP time required to ensure that support personnel had delegated cases to work with and appropriate supervision appeared to actually be shifting the service away from the participants' ideal. Supervising SLPs were left with either little or no time to serve some clients themselves or to collaborate with teachers or parents reducing the spectrum of services available to clients and the possibility of tailoring those services to clients' home and school environments.

Ultimately, significant role conflict was evident because the participants' current practice did not reflect their ideal. All participants spoke of enjoying their work but finding the time and numbers management difficult. They wanted to do "what was best" for both their individual clients and the overall system but were often plagued with uncertainty about how to reconcile these micro and macro perspectives. Many enjoyed working with support personnel yet feared never being able to treat clients themselves.

Participating SLPs reported that the ability to intervene directly was at the core of their professional role and key to their work satisfaction, with one participant even going so far as to agree with a former SLP colleague's statement that never being able to do therapy was "soul killing" for a SLP (P13 U2-SO-T Int 1 LN 223). The significant role conflict in which the front-line SLPs worked under also raised concerns about their ability to practice ethically in their current circumstances. Finally, the role ambiguity revealed in my study echoed that documented in the American practice literature and therefore raised similar concerns about how role struggles were negatively influencing retention of SLPs in school practice (Edgar & Rosa-Lugo, 2007; Sanger, Hux, & Griess, 1995; Tomes & Sanger, 1986)

My review demonstrated that many of the front-line SLPs' experiences and dilemmas were not reflected in the practice literature, including those sources which were designed to guide front-line practitioners in Canada (CASLPA, 1998, 2004a). The professionals did not, however, stand alone. Their work was not isolated from its context. It remained to be seen if and how participants' practice was being facilitated, or inadvertently hindered, by factors in their work context.

CHAPTER SEVEN: FINDINGS AND DISCUSSION - ORGANIZATIONAL AND GOVERNMENTAL CONTEXTS

"The local is critical but it needs to go higher. We used to have a saying here, 'take chances for children - not with them.' Our systems need to keep that in mind."
(S4 R-SP-S Int 1 LN 1059-1172)

The work of front-line SLPs participating in this study was situated in both the health context of their employer and the education context where they served school-age children. These two contexts resulted in a hybrid work world that has been represented in Figure 3 in the following page. In this chapter, I identify and discuss the textual practices (for the purposes of this study, policies and procedures) within each context that coordinated and controlled the work processes and decision-making of front-line SLPs in the study region. I also address the influence of the structure and characteristics of the relevant institutions and their management on front-line practice. Within all of these influences, both facilitators and barriers to practice are highlighted. I then argue that the ability of front-line SLPs to provide services and their work satisfaction were hindered by unresolved conflicts arising from their hybrid work world. Finally, I provide examples to demonstrate how a shared context might be negotiated to enable resolution of these issues.

Working in Health

As portrayed in Figure 3, the practice of front-line SLPs participating in my study was influenced by their immediate employment context in the local health region. Their work processes were also influenced by the organization, policies and practices of the provincial health ministry.

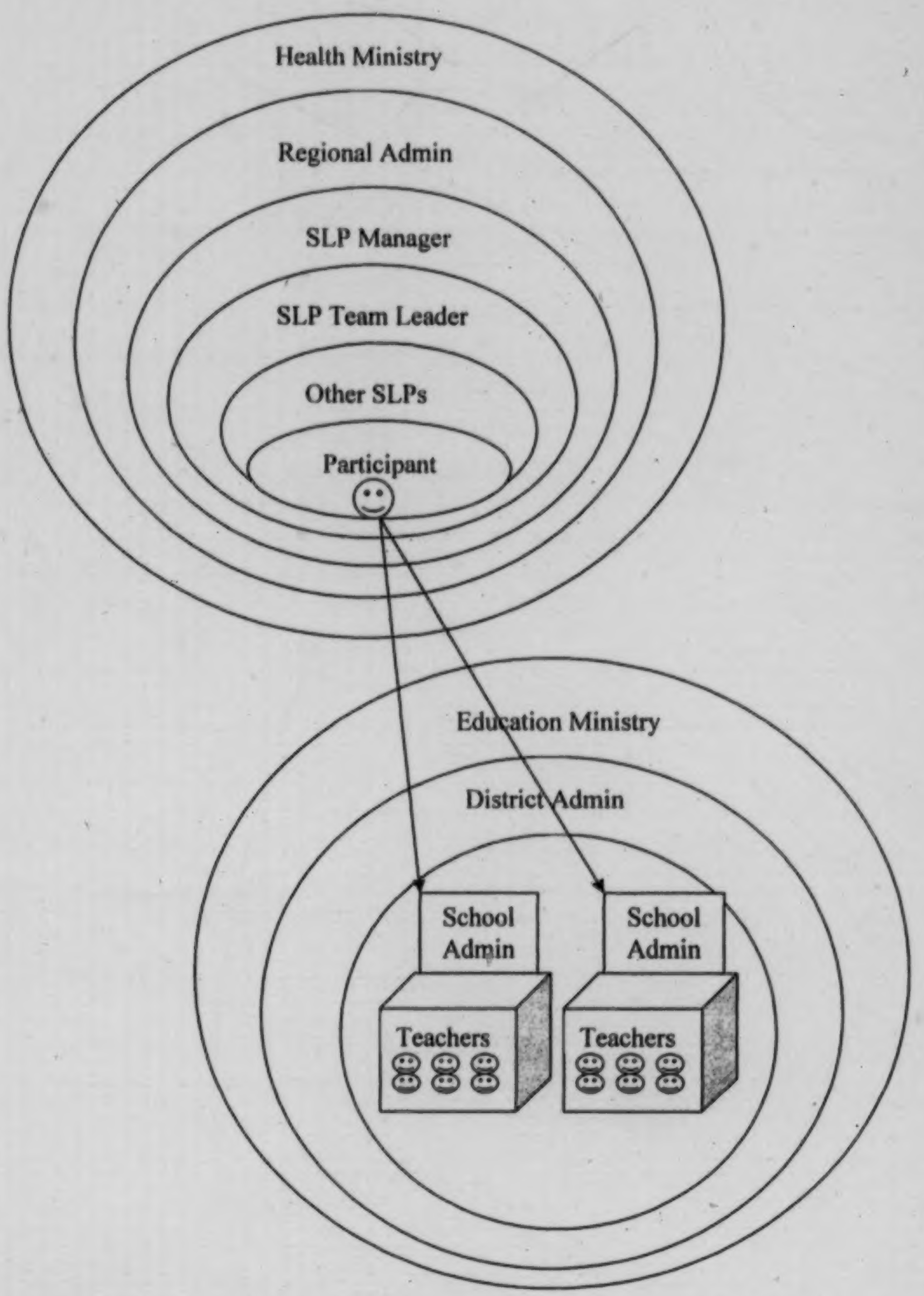
Local Health Region

With regard to the local health region, numerous factors were found to influence the practice of front-line SLPs. The most prominent among these factors were investigated.

Management Structure, Philosophy, and Style

Many participating SLPs viewed the fact that the regional manager had been a front-line SLP as a significant advantage. They indicated that their manager understood

Figure 3. Contextual Influences on Front-Line Practice


Health Ministry
Regional Admin
SLP Manager
SLP Team Leader
Other SLPs
Participant
Education Ministry
District Admin
School Admin
School Admin
Teachers
Teachers

the realities of front-line practice and was therefore better able to support them than someone without front-line experience who, they assumed, would not be as able to understand the demands placed on them. Participating SLPs reported satisfaction with the manager's style of leadership, which was perceived as flexible and democratic. They valued the opportunity to work together in teams, contribute to regional planning and manage their own caseloads. The front-line SLPs praised the manager's skills in dealing with difficult people on their behalf, ability to be strong and clear in negotiating agreements with partners, and pragmatic yet active approach to problem solving. As S7 said, "You don't want someone who's all talk and no action" (S7 U1-SP-T Int 1 LN 702).

Interviews with the regional manager affirmed the front-line SLPs' perceptions. Without prompting, the manager formulated a description of ideal practice for front-line SLPs serving school-age children that was markedly similar to that expressed by the front-line SLPs, stating that "the ideal job would be to be able to have a variety of service delivery models where you use the service delivery that's most appropriate for the child and not what you have available to you" (MSLP Int 2 LN 14-16). Speaking of the administrative role, the manager emphasized the importance of having a vision and time to build capacity in the department to make that vision a reality. The manager perceived that the overall management structure of the local health region was a significant facilitator of the management philosophy and style valued by the front-line SLPs in that it featured professionals from the specific rehabilitation professions managing front-line professionals from their fields and working together to advance rehabilitation throughout the region.

The positive influence that a supportive management team can have on the work satisfaction of front-line SLPs should not be underestimated. When asked about their satisfaction with their current positions, participating SLPs spoke of this support – from both regional management and local colleagues. Indeed, it appeared that perceiving a supportive workplace partially indemnified front-line workers from the frustrations of their positions.

During the time of the study, nearly all the pediatric SLP team leader's time was taken up by representing the department on a provincial team working to develop a system for sharing health information. The team leader's inability to perform staff support duties likely significantly constrained management's ability to facilitate front-line practice. The manager noted that performance appraisals on front-line staff had been postponed and that SLP working groups were functioning with more limited support. This constraint pointed to the most significant barrier that management perceived on efforts to assist front-line employees – time. The manager bemoaned not having enough time to build specific skills and talents in SLPs, suggesting that everyone was too busy managing their current duties. Participating SLPs and management both noted that school personnel frequently complained about front-line SLPs taking time away from schools to attend regional planning meetings. Occasionally the front-line SLPs also questioned whether the frequency of these meetings compromised their ability to provide quality services to students. There appeared to be a need to balance providing the front-line SLPs with the opportunities they so strongly valued to be a part of the planning process while protecting their ability to serve the students on their caseloads.

Staffing: SLPs and Assistants

Staffing levels were an aspect of the organizational structure recognized by both front-line SLPs and management as having a significant influence on service delivery. Health region management regarded staffing as involving both SLP and assistant positions affirming that the use of support personnel was well established in the work setting. For those with only surface awareness of the workload difficulties currently plaguing front-line practice, the influence of staffing could perhaps be viewed as straightforward and justifiably summarized as simply "lack of staff constrains service delivery, more staff needed to facilitate service delivery." After experiencing and discussing the situation in the region with both front-line SLPs and management, however, it became clear that such a brief statement would only scratch the surface on a much larger issue and so the influence of staffing levels was further investigated.

Speech-language pathologists. Several factors within the health region SLP staffing plan facilitated front-line practice. The ability to make local adjustments in staffing allocations to individual schools was viewed by front-line SLPs as a critical aspect of their ability to provide the best possible service to all students. The close involvement of the regional manager with the recruitment of new SLPs had a positive effect on SLP staffing levels. This involvement included personal contact with potential recruits and promotion of practicum placements for SLP students. The flexibility of the SLP staffing plan was a strong contributor to the job satisfaction of the front-line SLPs. They valued the opportunity to request different assignments and greatly appreciated management's willingness to work with employees who wanted only part-time allocations and individualized scheduling of work hours. The flexibility in staffing also allowed for recognition of individual SLP's interests and expertise. For example, one participant with a particular interest in paraprofessional service delivery had arranged for a position requiring extensive supervision while another with expertise in fluency disorders had arranged to dedicate some time to providing consultation to other SLPs throughout the region.

The regional manager described a need to remain accountable to the education partners in the student health initiative funding partnerships in terms of the SLP staff time available to their schools and districts. On the front-line in rural communities this sometimes meant that SLP time was not pulled back from schools to accommodate an excess of preschool clients, potentially interfering with taking a community approach to addressing speech and language issues. Vacant positions and staff turnover also constrained service delivery. Even if permanent positions were filled, management contended with the need to staff maternity leaves on a nearly continual basis. Management attempted to provide coverage for areas with staff shortages by asking for volunteers among working staff members. This type of coverage was often very limited in both duration and frequency of visits. Turnover in staff also resulted in SLPs taking on new assignments and therefore new caseloads. The front-line SLPs acknowledged that service delivery was constrained for at least the first year of service to a new caseload because it took time for them to understand and plan for the needs of the clients and to be able to build relationships with parents and school staff members. Concerns expressed about the impact of staff turnover on services were consistent with those expressed by rehabilitation therapists in Burnett's 2003 study.

SLP assistants. Front-line SLPs and management were in agreement that SLP assistants were an important part of the service delivery team, but an aspect that was not without significant implementation challenges. Although all preferred to avoid having new SLP graduates supervise assistants, this was sometimes unavoidable in the rural areas. In those cases, attempts were made to provide mentoring support and to retain lower caseload sizes. Other challenging situations arose when rural SLPs were assigned to supervise assistants who were not based in the same site office. Management recognized that this was not an ideal situation but were sometimes tied into employment agreements that had been negotiated by previous health regions and therefore did not accommodate new patterns of school coverage.

Availability of appropriately trained assistants was a concern of the front-line SLPs that was shared by the management. Although the manager anticipated moving towards requiring applicants for assistant positions to have the college-level speech-language pathologist assistant diploma, there was concern that the current training programs did not provide enough practicum experience resulting in a need for the region to provide significant on-the-job training. Both front-line SLPs and management reported that the most capable SLP assistants hired by the region were often those with early childhood education diplomas and significant on-the-job training, and they expressed concern that they would no longer be able to hire individuals with this type of background if they started to require the specific SLP assistant training program. The push towards requiring applicants to be graduates of SLP assistant training programs appeared to be more related to the hiring of untrained assistants by the school districts. Both front-line SLPs and management reported feeling that the health region would have to require future applicants for assistant positions to be graduates of SLP assistant training programs in order to make the case that school-based SLP assistants should also have that qualification in future negotiations with school districts. The influence of school-based SLP assistants will be discussed further in the section addressing the education context.

The focus on implementation challenges was striking upon review of my notes and discussion transcripts about the use of SLP assistants in the region. Thinking, too, of how many of the front-line SLPs reported having little or no time available to provide direct intervention once their supervision responsibilities were met, I came to wonder whether the staffing mix in the region was driving the service delivery model instead of the other way around. There did not seem to be a formal plan for integrating the paraprofessional service delivery model as *one* aspect of a range of service delivery options. In the absence of such a plan, it appeared as though the paraprofessional service delivery model might be crowding out other options.

Policies and Practices

When observed and in discussions of their practices, front-line SLPs frequently referenced health region policies and practices. Often, however, and as predicted by the literature on institutional ethnography, specific policies were not quoted, instead SLPs simply reported on the way tasks were typically handled without being able to articulate whether they were being guided by a policy or just common practice within the region. Front-line SLPs typically viewed regional policies as a necessary evil; important for their ability to standardize and improve practice across the region but challenging to keep up with, especially for those new to the region due to changes in health region boundaries.

Reviewing all of the policies and practices that had some influence on front-line service provision would be beyond the scope and intent of this study. In keeping with institutional ethnography, I reviewed the policies and practices that were the most clearly evident examples of "processing people through text" (Smith, 1999) from observations and discussions with front-line SLPs and which appeared to result in the most conflict. To facilitate discussion, these policies and practices have been grouped into three areas; those related to determining and managing caseloads, those related to negotiating the school setting, and documentation.

Determining and managing caseloads. Several health region policies were identified as having a significant influence on how front-line SLPs determined and managed their caseloads. The *Priority Classification Summary (PCS)* was a single-page guide designed to assist SLPs in determining an individual client's priority for treatment while the *Quota System* was a corresponding single-page chart designed to assist them in determining the maximum number of clients they should see at each school in a specific month (caseload target). In addition, front-line SLPs had access to an *Agent of Change Process* designed to facilitate the involvement of a parent or other adult with therapy process, a *Treatment Waiting List* procedure designed to help them deal with clients whom they were unable to immediately treat, and a *Treatment Ceiling* procedure designed to cap service to most clients after a specific period of treatment.

While all of these caseload determination and management policies were undoubtedly written with good intentions of providing overburdened SLPs with a consistent process for establishing and managing their caseloads and were typically appreciated by front-line SLPs for that reason, they were not entirely effective or defensible in practice. While a few of the front-line SLPs seemed to use the quota system effectively, the majority did not appear to completely understand the rationale behind the procedures which lowered their commitment and curtailed consistent use. This lack of understanding may have been due to internal staffing turnover and changes in health region boundaries which introduced new staff members to the region. After reviewing all of the information, however, I came to hold the point of view that there were deeper issues with the policies and procedures themselves (for an example, refer to Appendix H, for a more detailed review of the *Priority Classification Summary* and *Quota System.)* The procedures were created at different times, resulting in an apparent "layering effect" where more than one procedure addressed the same issue. Evidence supporting the appropriateness and efficacy of the procedures was often lacking, or at least unreported. This critique is not intended to denigrate the valiant policy-making efforts of both management and front-line SLPs within the study region. The policy issues noted were understandable given the dearth, noted in the literature review, of speech and language services administration and caseload management resources specific to Canadian practice.

Negotiating the school setting. Task prioritization agreements with local school districts and policies addressing both services to students assigned "severe disability" codes with Alberta education ministry (Alberta Learning, 2004b) and front-line SLPs' work with school staff significantly influenced how front-line SLPs negotiated the school setting. The regional manager had negotiated agreements with school districts throughout the region as to which tasks would be attended to first by front-line SLPs at the beginning of the school year. The agreements likely served the intended purpose of appearing to accommodate requests from school districts on a program-wide basis and therefore fostering goodwill with school district administration. However, they actually had limited discernable influence on front-line practice because SLPs would likely have prioritized the tasks addressed by the agreements in the same way on their own. As well, they did not address the front-line reality of large caseloads that often prevented SLPs from accomplishing the prioritized tasks until the end of October or middle of November.

A policy on *dual service provision* addressed the situation of health region SLPs working with students who appeared eligible for services from the Alberta Education-funded regional consulting teams. The policy stated that front-line SLPs would meet with school principals to discuss referrals to regional consulting teams for all students who appeared eligible at intake or after an initial assessment. Once an assessment consultation with the provincial consultation team was initiated, health region SLPs were directed to discharge the student from their caseload. A need to direct health region speech and language resources to children with mild/moderate/severe disorders who do not have access to other services or funding was stated as the rationale for the policy. An allowance was made for further involvement of health region SLPs in what was termed as "exceptional" cases if the manager received a request from a regional consulting team SLP for direct therapy provision. The ability of the regional consultation teams to assume service to the children affected by the policy did not appear to be considered in the making of the policy. On the front-line, confusion about the implementation of the policy was considerable, again likely because many SLPs were new to the region due to boundary changes. For example, some of the front-line SLPs reported giving their school administration one year of notice before policy enforcement. Other SLPs, however, understood that the policy was to be enforced immediately and acted accordingly. The contextual interaction with the regional consulting teams has been discussed further in a later section in this chapter on the education context.

Speech and Language Services also had policies and practices addressing how SLPs would be involved with school personnel. For example, a policy specifically stated that health region SLPs would work with only one school-based SLP assistant per school. The policy was designed to facilitate SLPs having enough time to provide training, supervision, and support to assigned assistants. Front-line SLPs supported the implementation of this policy because it helped to consolidate their activities with school-based assistants. Another policy stated that SLPs would not provide programming or supervision to teaching assistants assigned to work with one student or in the classroom but would instead discuss programming with teachers who would then be responsible for setting up a program for the teaching assistants. This policy was consistent with guidelines for the use of support personnel available from the Canadian Association of Speech-Language Pathologists and Audiologists (CASLPA) at the time of the study. Front-line SLPs were observed to be struggling with consistent implementation of the policy, however, often resorting to meeting directly with teaching assistants in order to maintain consultation services to needy clients. They justified this action by stating that the organization and culture of the schools made direct consultation with teachers difficult. While no formal policy could be identified, many front-line SLPs also reported that they were only to consult with teachers about the development of individualized program plans (IPPs) for students upon request; they were not to write these plans nor were they to permit teachers to attach their speech and language programs as addendums. These practices appeared to have the understandable intent of reducing excessive demands on limited SLP time and encouraging teachers to embrace their appropriate role as leaders of the IPP process. As noted in the literature review, however, SLPs have been acknowledged as having expertise in both language and literacy areas that is critical to the successful education of students, particularly those with special needs who would qualify for IPPs.

Indeed, the health region policies and practices designed to help front-line SLPs negotiate the school setting often seemed to be at odds with the greater involvement in the educational process that many front-line SLPs saw as part of their ideal role with school-age children. The policies and practices had the potential to reduce, rather than enhance, the ability of front-line SLPs to respond proactively to the circumstances of individual students, teachers, and schools. Strong and effective partnerships with both families and school teams were strongly valued by participants. The officially sanctioned work practices seemed to increase the potential for alienation of school team members as well as the risk of triangulating parent, teacher, and SLP. Indeed, concern about preserving positive relationships with these two groups may have been behind the actions of front-line SLPs who "adjusted" policies in their day-to-day practice. These policies adjustments by front-line practitioners were anticipated based on the concepts of institutional ethnography in which such case-by-case policy adjustments are seen as critical in allowing a large system to provide effective service to individual clients (Smith, 1990).

Documentation. As noted in the discussion of their practiced role, front-line SLPs were responsible for extensive documentation. For each client served, they processed a series of documents ranging from the referral and yearly consent forms through assessment reports and treatment summaries to discharge records. Forms or templates were provided by the health region for their use in completing these tasks. In case notes in client files, they recorded time, observations, activities, results, contacts, and communications. There were also paperwork requirements related to caseload selection and management including forms necessary to comply with various health region policies including the *Priority Classification System* and the *Quota System*. Each SLP also completed paperwork required for the collection of Alberta Health statistics. Filing of paperwork was considered part of the documenting role.

The literature review demonstrated that documentation is an acknowledged and necessary part of the SLP role. The fact that many of the front-line participants had developed their own, additional, forms of documentation to help them manage their caseloads demonstrated their recognition of its value. Their acceptance of the need for documentation should not be equated with complacency. They argued the changes to individual templates and forms and additions of new paperwork interfered with their ability to work to capacity because learning new ways of doing things took time. Because of this interference, they urged careful consideration of the costs and benefits of changing documentation practices.

While front-line SLPs appreciated management involving them in the process of reviewing and creating documentation, they reported that more could be done to assist them with meeting documentation demands. Specifically, they reported limited clerical and technology support. Reductions in the time they had available to serve clients because of the need to complete secretarial tasks was very frustrating and demoralizing to front-line SLPs. In terms of technology, in some site offices up to four employees shared a single computer. A few front-line SLPs used laptop computers supplied by the region but these appeared to be in short supply. Several participants argued that the health region failed to recognize the potential of technology to increase their professional efficiency and efficacy.

The amount of health region documentation completed by front-line SLPs and the corresponding time required was also a point of contention with local education authorities. Just as they resented the time taken away from school practice to attend planning meetings, local education officials and educators expressed uncertainty about the benefits of SLP documentation practices.

Placement Influences

The characteristics of front-line SLPs' particular placements in the region resulted in both quantifiable and qualitative differences in their work lives which clearly influenced their practice. Placement characteristics included the site offices to which they were assigned, whether they were placed in rural or urban settings, whether they practiced alone or as part of a team, and whether they worked only with school-age children or with preschoolers as well.

More concretely, though, and as discussed in chapter four, it became evident during the study that there were significant differences across sites in the office space available to front-line SLPs. At times, a lack of appropriately private office space and access to technology constrained practice.

Similar to the rural SLPs in CASLPA's *2003 Caseload Guidelines Survey*, participants in this study who practiced in rural areas reported that distance and isolation presented significant challenges to practice. Participants elaborated on the distance constraint by describing time-consuming and fatigue-provoking travel to small and scattered rural schools. Interestingly, participants demonstrated that many aspects of rural life often assumed as limiters of practice could also have positive effects depending on the perspective of the practitioner. For example, while isolation was viewed as a constraint in terms of limiting access to both the wider range of tests and materials available in the region and to other SLPs for consultation, it could also provide greater independence and reduced intrusion of negative regional politics. The lower population base in rural areas resulted in lower numbers in disorder categories meaning that group services were not feasible but also that waiting lists were less frequent. Rural SLPs felt that they had less opportunity than urban SLPs to specialize in one area of practice or one age group but reported a corresponding advantage in the necessity to maintain a broad spectrum of clinical skills. Small rural communities offered fewer children's programs to help promote social and language development but participants spoke of the advantages of knowing clients, families, and school staff members as members of the community and having clinical successes acknowledged and celebrated by the wider community.

Some of the rural SLPs were the only SLP allocated to their site offices and were therefore described as being in "sole practice". Sole practitioners reported that their independence could facilitate practice as they did not need to negotiate with other SLPs as to how services would be provided and were often free to adopt a community-wide focus to their caseload management. Their isolation from other SLPs was in turn seen as having the positive side effect of encouraging them to develop more collegial relationships with other healthcare providers working out of the site such as public health nurses. They did recognize the significant potential for limited access to other SLPs to constrain their practice, reporting that a critical component of adapting to sole practice for a SLP was developing an ability to recognize for oneself when consultation and support were needed and to develop the means of accessing this assistance remotely.

Positions serving only school-age clients were available throughout the region with the exception of the sole practice sites in some of the rural areas. While serving more than one age group was more common in the rural areas, many rural clinicians served both preschoolers and school-age children by choice. In addition, numerous SLPs in the urban sites had specifically requested a split focus.

Front-line SLPs who served only school-age clients valued the opportunity to work outside the office and in the public school setting. They appreciated the greater independence and focus of school-age children in comparison to preschoolers and the ease with which they were able to build a rapport with them. Not having to individually schedule appointments on a weekly basis was seen as a plus. Making a difference to the education children received in public schools was often important to these clinicians. They enjoyed working with other adults, both assistants and teachers, through consultation and team-teaching. They reported that their efficacy with the population came largely through their ability to transfer language and literacy development skills to others. The focus on one population was considered a positive for allowing them to build a focused skill set. The still considerable age range available in the school-age population was valued for providing variety. Front-line SLPs who worked only with school-age clients reported significant constraints on their practice. Any contact with clients' families required extra work and the close partnerships with families many front-line SLPs desired often seemed out of reach. The number of different school sites and high caseload sizes resulted in a demanding schedule which sometimes required considerable travel. Some front-line SLPs reported that the sense of balancing many independent caseloads could engender a corresponding and disorienting lack of continuity from day to day. Many struggled to retain a sense of efficacy. In these cases, the SLPs often associated efficacy with being able to do direct treatment and were frustrated by feeling as if they had to work in a less personally satisfying consultative model in order to reach a greater number of clients. They struggled with uncertainty as to whether they were making any difference in the lives of the clients they wanted to help. This uncertainty was similar to that expressed by the rehabilitation therapists in Burnett's 2003 study.

Front-line SLPs who served both preschool and school-age populations valued the opportunity to see preschool clients at their office location, thereby avoiding travel and providing greater contact with families. They enjoyed spending time with younger children. They reported that it was easier to have a satisfying sense of personal accomplishment when directly serving the preschool caseload. Client gains were more observable and more readily attributable to their input. They enjoyed the increased variety and opportunity to maintain and develop their skills in two service delivery areas. In some cases, the clinicians followed the same children from preschool to school and were therefore able to personally assist with that transition which provided a great sense of satisfaction and long-term relationships with families. Constraints of serving two populations related to the sense of working two separate jobs that often resulted. Front-line SLPs who served both preschoolers and school-age clients often struggled to maintain the assigned allocation per population. The majority reported that keeping preschool hours separate from school hours was critical to avoid the caseload demands of one of the populations resulting in diminished service to the other. In contrast, the sole practice SLPs who served both populations out of necessity in rural areas were more likely to focus on serving all the children in their communities in an equitable manner regardless of age. Serving two populations resulted in front-line SLPs having fixed weekly schedules to establish consistent days of the week for preschool appointments. These schedules limited their ability to accommodate the inevitable changes in school schedules that occurred due to cycle/rotation scheduling of school activities, inservice days and field trips.

In some respects, the front-line SLPs in the smaller urban offices and larger rural offices seemed to have the best of both worlds as they typically had adequate office space and access to tests and materials, ready availability of SLP colleagues for consultation and support, and some flexibility in population assignment. Although attention to these factors by management would undoubtedly positively influence the job satisfaction and practice of front-line SLPs in any work setting, some differences in placements cannot be resolved. The question then becomes one of how any positive aspects of these differences can be highlighted and negative aspects minimized.

Provincial Health Ministry

Decisions made by Alberta Health and Wellness, the provincial health ministry, and reflected in changes to organizational structures and policies and procedures were observed to influence the practice of front-line SLPs. These decisions clustered in four main areas of health region organization, funding and mandate, provincial coordination, and record-keeping.

Health Region Organization

During this study, I observed the influence of the provincial Health ministry's organization of health regions on front-line practice. Two large-scale reorganizations of health region boundaries had occurred within the 10 years prior to this study. Each reorganization necessitated restructuring of the speech-language services program within a new, larger boundary with more sites and different travel patterns between and among sites.

Sometimes decisions were made to accommodate these new sites that were regretted by future management. For example, the manager for speech-language services reported that a decision made to provide assistant coverage to sites added in the first regionalization in 1994-1995, even though no additional funding was provided, still influenced the region's use of support personnel at the time of the study. This decision meant that for the first time in the history of the region, support personnel were not allocated to SLPs on a one-to-one basis, setting the precedent for future service delivery and making it difficult for the manager to retrench from that decision despite a personal view that a one-to-one allocation would be much more efficient and effective.

Upheaval and stress for front-line SLPs was also a negative side effect of health region reorganizations. Many of the front-line SLPs who participated in this study had experienced two significant reorganizations of Alberta health regions. Although they valued current management's involvement of them in the decision-making and felt that it was critical to the ultimate success of the new program, all front-line SLPs who had been involved in health region reorganizations recognized that the time required to negotiate which policies would become standard within the "new" speech-language services program, to learn the policies, and to apply them significantly reduced the time they had available for direct services to clients. They also spoke of difficulty explaining new policies to their local school contacts who could not understand why they were no longer able to do things that may have worked well locally. The front-line SLPs who were newer to the health region felt their personal partnerships with local school team members were jeopardized by unavoidable gaps in the emerging relationships between their new management and school district management and by changes in Student Health Initiative Partnership communication channels. They recognized that new linkages needed time to form to replace those put in place by their previous administrations but were wary of their context shifting in ways they did not yet understand. There were also some unavoidable feelings of being "swallowed up against their will" (S12 U2-SP-T Int 1 LN 438) that went along with more positive feelings of renewal and new opportunities.

Funding and Mandate

Perhaps the most obvious way that front-line SLPs perceived the provincial health ministry as influencing their work was in the area of funding and mandate. Many of the front-line SLPs maintained that increased and protected government funding for SLP positions was the only way to improve their job satisfaction because it was the only way they saw to allow them to achieve their desire to focus on early intervention and prevention and reduce their waiting lists. Investigation of the funding and mandate issue, however, revealed that the potential for provincial health ministry influence in this area was not as high as the front-line SLPs perceived.

While the regional manager also held the view that the resources and availability of service providers were driving current service delivery offerings and that more SLP and assistant positions were needed to allow the use of service delivery models that best met the needs of individual clients, the manager was quite aware of the vagaries of the current funding system. In an interview, the manager spoke of the lack of a hard mandate requiring health regions to provide a specific level of speech-language services, noting that a "global funding model" meant that requests for additional staffing were considered against requests for staffing and equipment for acute care facilities. While the manager acknowledged the region as generally quite supportive of speech-language services, there had not been an increase in funding for the school-age program in the three years prior to the study despite evidence of increased demands and proposals for increased services. The manager also noted that speech-language services did not operate with population to service provider ratios like those available in school systems where specified increases in student enrollment automatically resulted in a staffing increase and that this difference between health care and education funding was not well understood by school district administrations and local school teams. Student Health Initiative Program funds were acknowledged as having provided a significant boost to school-age service delivery when first announced. They were not, however, seen as sustainable as the amount allocated did not rise along with staffing costs resulting in the need to carefully budget to take into account pending settlements on unresolved union contracts. The manager reported that because of these funding issues, the only way that funding for SLP staffing would be significantly increased was if a special initiative was announced by the government.

In my discussions with a management representative from Alberta Health and Wellness, however, that individual emphasized the ministry's reliance on the "global funding model" described by the manager for speech and language services to provide funding to health regions throughout the province based on population size and measures of determinants of health such as socio-economic status. When asked about how much direction was given to the health regions on the allocation of funding, the Health manager stated that decisions about funding allocations were made by the chief executive officers, vice- presidents, and managers of the individual health regions according to a broad service vision established by the board of directors. There were no mandated requirements to fund and provide speech-language services at a particular level. The Health manager acknowledged differences in services across the regions due to this influence of senior management but stated "shock if there were to ever be some specific program targeted funding" (AH 1 Int LN 72-73). In a discussion about the Student Health Initiative Partnerships (SHIP), the Health manager commented that the SHIP program was likely the closest thing the province would ever have to dedicated speech-language service funding but that the funding did not come from any one ministry but rather from the treasury branch with the Education ministry serving as the banker. The Health manager acknowledged that SHIP funding was not specifically tied to the delivery of speech-language services but rather to the priorities of the specific partnerships but noted that all partnerships had selected speech-language service delivery as one of their top concerns.

Provincial Coordination

Front-line SLPs with extensive experience practicing in the province reported feeling that there had been better coordination between speech and language programs prior to the first reorganization into health regions. They spoke of meetings between departments that encouraged valuable information sharing and a provincial consultant who advocated for and coordinated speech and language services-related initiatives across government ministries. They did not sense that the same level of coordination was occurring at the time of the study, commenting instead that, as S4 summarized, "everybody is reinventing the wheel" (S4 R-SP-T Int 1 LN 1059). They did not mention an informal network of SLP managers and team leaders that was operating at the time of the study, seemingly unaware of the information-sharing potential of this group. They argued instead for a return to a provincial consultant who would be a presence representing their interests at the level of the provincial government. They were aware that a provincial review of speech and language services was ongoing and were hopeful that better coordination of services across the province would result.

In an interview with a manager who was working on the provincial review of speech and language services for Alberta Health and Wellness, I asked about the ministry's role in the review and specifically, about if and how the review could be expected to influence coordination of speech-language service delivery across the province. The review manager acknowledged a tension between having guidelines and service expectations that apply across the province and recognizing the specific needs of individual health regions. The review manager also agreed that information sharing was important and reported that the provincial review was one way of gaining some consistency through information-sharing and that the possibility of pulling groups together for continued information-sharing was being considered as an implementation strategy in the review. It was noted that members of the speech-language pathology professional community should not expect specific guidelines or funding to come out of the provincial review reporting that the health ministry had moved away from providing specific guidelines and funding and towards local health region decision-making.

Record-Keeping: Statistics Collection and Electronic Health Records

Front-line SLPs participating in this study were observed completing statistical reports for what they referred to as "ACCS". Upon further investigation, ACCS came to be understood as the *Alberta Ambulatory Care Classification System*, a statistical collection requirement of Alberta Health and Wellness. The *Alberta Ambulatory Care Reporting Manual* (Alberta Health and Wellness, 2005) described ACCS as having been designed to "create a fully integrated ambulatory care patient classification system for acute care facilities" (p. 1). Despite being located primarily in community health facilities, speech-language services were required to submit utilization data under ACCS. The system was not intended to be a comprehensive data collection system as it does not include workload statistics, costs, service recipient satisfaction results, or quality assurance elements but rather strictly addresses utilization of services. Mandatory data elements fall into administrative, demographic, and clinical categories. Clinical data elements included the service visit date, provider type, service code, mode of service, disposition of case, diagnosis codes, and intervention codes. The data elements were designed to be useful in population based funding. Alberta Health and Wellness had developed a relative value index (RVI) for funding and other resource allocation decisions. The RVIs were based on the patient specific costs in ambulatory care programs collected by some costing regions participating in an Alberta Costing partnership. The

ACCS reporting manual noted that health regions could collect more than what was needed for ACCS and have the required data elements abstracted out but they could not collect less. The manual also emphasized that "consistent and accurate collection" of the data elements was critical to the funding process (Alberta Health and Wellness, 2005, p.1)

This official description of the ACCS statistical collection contrasted with the realities of front-line practice. Participants expressed serious concerns about the meaning of what they were recording. For example, they noted that important discussions with caregivers about yearly consent forms could not be statistically recorded because a file was not yet open. Despite the frequency of consultation as a service delivery option, the statistical system would not allow "consult" to be recorded as an activity unless it was attached to an "assessment" function. The widespread use of speech-language assistants raised concern about appropriate ways to quantify their contributions. Front-line SLPs felt that having assistants collect their own statistics could imply that their contributions were independent of those of the supervising SLPs.

It is also important to note that ACCS was not itself a computerized data collection system; health regions across Alberta had purchased various data collection systems to allow employees to collect ACCS data along with other region-specific data elements. With changes in health region boundaries, this variation had resulted in different statistical collection systems being used within the same health region while each site awaited the arrival of a new universal system. The variations in systems significantly reduced the usefulness of the statistics. For example, different systems defined wait time differently, preventing a common and definitive picture of wait times across the province.

Some of the statistics collection systems were more computerized than others but none were completely computerized. Front-line SLPs in U1 actually recorded monthly statistics on paper forms and manually totaled the data, reportedly because it took too long to get information back from a central data entry services. Some reported taking up to one ½ day per month to catch up on statistics. Technology did not appear to be used appropriately to reduce time and provide more useful and timely information. The education authorities were well aware that the time taken to complete statistics could have been used to directly serve clients. The front-line SLPs were not against collecting statistics but plead for a system that would as S4 stated, "help us learn and help us make our case for service" (S4 R-SP-S Int 1 LN 1059-1172). They were unable to specify any benefit to their current statistical collection activities.

At the time of the study, the pediatric team leader for speech-language services was spending nearly all of her work time assisting with the development of an electronic health record. An American software company had been hired to supply all seven of Alberta's non-metro health authorities with a common health information system. A central shared data center was designed to eventually interface with Alberta's provincial electronic health record, allowing privileged users access to client health information in both metro and non-metro health regions throughout the province. The idea was that in addition to the electronic health record, one health information system would allow the seven non-metro health regions to meet their provincial reporting requirements and participate in provincial and pan-Canadian information management and technology initiatives. During an interview with the team leader, it was specified that additional perceived advantages of the new system were easier sharing of information across sites and regions and less training of new staff transferring in from other regions.
Concerns about the new system included the potential for the design of the software system to drive what was being collected, restricting users to limited numbers and types of procedures and making the tracking of wait times cumbersome. In order to allow reports to be shared as part of an electronic health record, the front-line practitioners would have to use a reporting format set up by the system, instead of being able to attach their own reports. The team leader noted that the computerized format had been originally designed for acute care doctor reports and was not very "school-friendly." The team leader felt that the schools could be sold on the benefits of the new system in terms of allowing easier information sharing. The new system was also not expected to completely remove the need to manually collect some statistical information. Indeed, the team leader anticipated that the time taken to complete statistical requirements would actually increase in the short term as front-line practitioners became accustomed to the new system. In summary, it appeared that the current means of provincial record-keeping

were not enabling of effective and efficient service on the front lines and that there was significant risk that new systems would pose the same challenges.

Working in Education

Similar to the health work context and as portrayed in Figure 3, the practice of front-line SLPs in my study was influenced by the local education scene as this was where they worked with school-age children. Their work processes were therefore also influenced by the organization, policies and practices of the provincial education ministry. Exploring these influences further illuminated the tensions perceived in the front-line SLPs' currently practiced role in regards to their work with educators.

Local Education Scene

Several factors in the local education scene became issues for front-line SLPs. Of greatest significance for the purposes of my study were the multiple players, local special education initiatives, communication channels, and understanding and accommodation of speech-language services.

Multiple Players

The multiple players in the local education scene, including public and Catholic school districts, private special needs, Christian schools, and homeschooling families, challenged front-line SLPs and speech-language service administrators because each player had different expectations for service. High population levels in special needs schools necessitated special service agreements while low population levels in Christian schools became a barrier to consistent service as management could not justify sending staff members out on a regular basis. Home-schooled children were considered to be part of the caseload of school-serving SLPs but serving them necessitated office time for appointments which many school-serving SLPs did not automatically schedule. As a result, service to home-schooled children was often dealt with after the regular school day. Even within the large public and Catholic school districts, site-based management of schools resulted in differences in scheduling, staffing, and regular and special education programming that front-line SLPs had to consider when planning speech-language services for each school's caseload. Differences in school closure days across school boards prevented regional management from capitalizing on those days for SLP team meetings and professional development. As a single front-line SLP could serve public, Catholic, private, and home-schooled students, the complexity of dealing with the many different settings and expectations became potentially overwhelming. To the credit of regional administration, attempts had been made to reduce the number of organizations school SLPs served.

Special Needs Initiatives

Special needs initiatives brought forward by the various public and Catholic school districts and the education-health partnerships became part of the work context for the front-line SLPs. Identification, Pre-Kindergarten programs, and school-based assistants were three initiatives identified as having a significant, and largely negative, influence on the work of front-line SLPs.

Identification. At the time of the study, both the main public and Catholic school districts in U1 were working to establish kindergarten screenings. Although neither the front-line SLPs nor speech-language service administrators were consulted during the development of the screening process, they were directly affected by the initiative as all children who failed the screenings were referred for speech-language assessment. Extensive SLP time was required to complete follow-up testing and reassure parents when a high false positive screening rate was reported; the majority of children who failed the screening were subsequently discovered to have speech-language skills in the normal range. Screening received support in the literature review as an important SLP activity (ASHA, 1999; Minister of National Health and Welfare, 1985; Moore-Brown & Montgomery, 2001). The flaws with the current screening process seemed to relate to the failure to involve the SLPs in the planning stages.

Pre-kindergarten. Also at the time of the study, several school districts in the region were developing Pre-kindergarten classrooms for special needs children including those with speech-language delays/disorders. Entry into the programs required eligibility for Alberta Education special needs coding and funding. School district administrators and speech-language service administrators negotiated how front-line SLPs would be involved. In some cases, the school districts only wanted health region SLPs to provide student assessments while private SLPs would be hired to provide supervision of support staff in the classrooms. In these cases, the assessments were completed by preschool SLPs with no involvement of the school SLPs. In other cases, negotiations resulted in school SLPs providing consultation services to the staff of the pre-kindergartens while direct services continued to be provided by preschool SLPs at community health offices. In these cases, the school SLPs were simply asked to fit the extra consultation time into their original school allocations which resulted in reduced time for the traditional school caseload. The negative consequences of this system were recognized quite quickly by all parties and different agreements were to be in place for the year following the study, including greater use of private, contracted SLPs by the applicable school districts. Pre-Kindergarten programs did, however, create a significant contextual barrier to effective and efficient speech-language service provision during the period of the study demonstrating the enormous influence of local special education initiatives on front-line SLP practice.

School-based assistants. As previously noted, many front-line SLPs worked with assistants who were hired by school districts, known in the region as "school-based assistants." While the health region had created a policy to reduce the number of these assistants to one per school, there did not seem to be any policy or standard procedure for considering the availability of a school-based assistant when determining the schedule of a health region SLP assistant. Some front-line SLPs worked with both school-based and health region assistants at the same school. Front-line SLPs typically had minimal, if any, involvement in setting the work schedules of school-based assistants, meaning that they often had to juggle their own work schedules around those of the assistants in order to maintain supervision. No written agreements appeared to be in place to address the supervision of school personnel by health personnel. For example, there was no written procedure addressing how a health region SLP would deal with the perceived incompetence of a school-based assistant. While several front-line SLPs noted that school administrations had been receptive to their concerns about some school-based assistants, the lack of written agreements had clear potential to put both assistants and SLPs in jeopardy if a complaint was launched by either party.

Communication Channels

The communication channels in the local education organizations influenced the practice of front-line SLPs in several ways. Gaps in communication between health region and school administrators and among special education coordinators for school districts, school administrators, teachers, and school-based assistants often resulted in front-line SLPs being the first to inform front-line school personnel of policy and practice agreements. For example, a local grade one teacher could very well be unaware that all front-line SLPs had been asked to serve kindergarten children first in the fall. Because they were the bearer of the news about changes, front-line SLPs found themselves in the position of defending policies and practices before being able to discuss local service needs. As S14 stated, missed communications resulted in "this kind of bumpy spot in the road of your relationship, where they don't clearly understand things" (S14 U2-SO-T Int 1 LN 2296-2330).

Interestingly, front-line SLPs also reported taking a role in communicating with front-line educators about Alberta Education special education coding and funding. They reported that they were often better-informed by their professional organizations and administrators about changes to speech-language-specific policies than were educators.

The differences in awareness between front-line SLPs and front-line educators may have resulted from differences in complexity and focus within the communication channels of their respective organizations (see Figure 3, page 172). Front-line SLPs were understandably focused on speech-language services and reported directly to their own regional manager. They collaborated with health region administration to determine how new policies and practices would be implemented. In contrast, the regional manager's counterpart in education systems, most often a special education coordinator, had many issues to address and did not communicate directly with teachers but rather with school administrators. Depending on their level of interest and involvement with speech-language services, school administrators may not have recognized the significance of policy and practice changes to their team members. In any case, it was clear that educators and SLPs were typically unable to base discussions of school, classroom, and individual needs on a shared understanding of their context.

Understanding and Accommodation of Speech-Language Services

Both front-line SLPs and the regional manager for speech-language services noted concerns with the understanding and accommodation of speech-language services in the educational context. They reported that front-line educators and educational administrators complained about front-line SLPs taking time away from direct service to schools in order to prepare, write reports, attend professional development opportunities, and participate in regional program development meetings. Conversations with several school principals verified these complaints. One noted that educators were required to do their preparations and paperwork outside of school hours including in the evenings so why not SLPs? Complaints of this type were often seen by those in the speech-language program as representing the education world's failure to appreciate the contributions of these off-site activities to the effectiveness and efficiency of the speech-language programs delivered when the front-line SLPs *were* on-site. This is not to say that front-line SLPs did not themselves express concerns about missing time away from schools. Indeed, they often maximized their time on-site by working overtime in order to be at distant schools when classes started, struggling with a minimum of office time, and avoiding taking holidays during the school year.

Other areas of misunderstanding between those providing speech-language services and the educational community included consent for service, supervision of support personnel, and space requirements. In each of these areas, procedures varied greatly between education and health. Teachers were reported to have difficulty understanding that front-line SLPs, as health employees, were required to have signed consent to see a student before they could, for example, even take that student out of the classroom to observe his or her speech. Many front-line SLPs as well as the regional manager commented on an apparent lack of guidelines for supervision of support personnel in the educational setting resulting in teachers and educational administrators not understanding the strict supervision guidelines used in speech-language pathology and other health professions. For example, special education coordinators were reported to have difficulty understanding that when SLPs delegate intervention programs to support personnel the SLPs remain responsible for that intervention and must, therefore, be able to ensure the program is carried out appropriately. In terms of space requirements, front-line SLPs reported that school administrators often did not fully recognize the critical need for quiet, appropriate, and consistent workspaces within their schools. They reported having worked in noisy gym offices and moldy shower rooms. While the SLPs acknowledged that most schools were struggling with space issues, difficulty in securing an appropriate workspace negatively affected their job satisfaction and increased their stress levels.

All of these areas of misunderstanding resulted in front-line SLPs sharing the view that their work was under-appreciated by teachers and educational administrators. S9's comment that "they look at us as such a separate entity and quite often we're the bad guys" (S9 U1-SO-T Int 1 LN 2243-2302) was representative of the concerns of front-line SLPs. Both they and their manager expressed the view that the misunderstandings and concerns were probably to be expected because of perceived widespread differences in the education and health bureaucracies and accepted some responsibility for harboring their own concerns about the practices of educational authorities.

Provincial Education Ministry

Decisions made by Alberta Education, the provincial education ministry, were also observed to influence the practice of front-line SLPs. These decisions clustered in two main areas of special education policies and regional educational consulting services.

Special Education Policies

The practice of front-line SLPs was influenced by Alberta Education policies related to identification of needs, coding and funding, and programming. These provincial policies affected the priorities and practices of local education authorities and their subsequent expectations for speech-language services. At times, these policies also influenced the activities of front-line SLPs directly.

Identification of needs. Provincial special education policies appeared to be behind the push by local school authorities to develop new means of identifying students with special needs. The standards for special education put forward by the provincial education ministry have consistently specified that school authorities are responsible for ensuring the early identification and intervention of students with special needs in education programs (Alberta Education, 1997, 2004a). Some questions surfaced about school authorities' success in fulfilling this responsibility, however, as the role was highlighted in the 2000 review of special education in Alberta. The review's final report recommended that the ministry, in the short term, emphasize communication and highlight this early identification and intervention responsibility to the school authorities and, in the long term, develop policy to support early identification and intervention (Alberta Learning, 2000).

At the time of my study, the biggest issue those in the speech-language services program had with the identification initiatives of school authorities related to a push to identify younger and younger children. In an interview with a representative of Alberta Education, I queried the intent of ministry policies on early identification. The representative reported that the intent of the policy was to encourage identification of special needs as early as possible in a child's school career or in the case of an older child who has developed a medical condition or experienced an injury or accident, as early as possible after onset (AE1 LN 279-287). The responsibility for identification of special needs in the preschool population was specified as lying with the health ministry or other groups. The representative noted that the special education funding available in Alberta to children beginning at the age of two-and-a-half might encourage some school districts to partner with other community organizations to boost preschool identification of special needs (AE1 LN 310-321). However, no specific direction to negotiate these types of partnerships was included in Alberta Education guidelines.

Coding and funding. The administration and provision of speech-language services were influenced in a variety of ways by the system whereby the education ministry developed special education codes to classify children and students with special needs and tied these codes to funding. Similar to the communication gaps that plagued the local education scene, numerous misunderstandings of, or possible failures to adapt administratively to, Alberta Education coding and funding policies in the education community were evident. For example, front-line SLPs reported significant pressure from school administrators to identify, by the end of September, mild-moderate speech-language delays and disorders in the kindergarten population. They were told the urgency was due to a provincial ministry deadline for submitting information on eligibility for funding. A representative of the ministry specified, however, that as long as children were registered at a particular school by the end of September, then that school had until the end of April to identify those children and they would then get the funding retroactive to the beginning of September (AE1 LN 582-594). While review of ministry documents affirmed this, in reality local school districts appeared to act to avoid the need for retroactive funding for accounting purposes. It was unclear, then, if Alberta Education's expectations in that regard were realistic.

Other aspects of the coding and funding system seemed to inadvertently encourage an antagonistic rather than a cooperative relationship between local school authorities and the health region speech-language services. This unintended result was most evident at the level of early childhood coding and funding for children aged 2 ½ to 6 years of age. School authorities were well aware that due to the age range for eligibility, the bulk of funding was available for preschool children and that the majority of special needs in this age group related to speech-language delays and disorders. They also knew that if they did not aggressively pursue early identification of these concerns in the preschool population, they would be faced with children with unidentified and untreated difficulties entering kindergarten with only one year of funding eligibility remaining when they could have started programming at age three and potentially had three subsequent years of funding. The urgency school jurisdictions experienced in getting these children identified so that programming could begin led some to either make demands on the speech-language services program that could not be met by current staffing levels or, as discussed previously, to develop their own identification initiatives. When they were able to secure early childhood funding for children on the basis of speech-language needs, school authorities frequently used Alberta Education funds to purchase additional private SLP services, claiming that the Health speech-language services were not adequate to meet the needs. While that claim may have been valid, the funds they were spending still represented public money being used to supplement public health services but in the most inefficient way possible as the private services were often secured at a costly hourly rate per child and private practitioners often traveled to the same school sites as the health SLPs. When questioned as to why a school district would not just hire its own SLP, a local special education coordinator noted that the education funding available was not secure enough to encourage this (C2 Int LN 196-198).

Front-line SLPs and their regional manager noted that Alberta Education's coding and funding system seemed to encourage school authorities to focus on funding rather than programming. They told anecdotes about school administrators being more concerned with the potential of report scores making a student eligible for funding than with the programming recommendations or follow-up. They also spoke of struggling to get the legitimate educational needs of students who did not qualify for coding and funding recognized such as students in grades 1 through 12 with significant speech disorders. When questioned about these issues, a representative of Alberta Education spoke of the need for school jurisdictions to return to the standards documents and recognize that, regardless of funding programs, they were responsible for the appropriate education of *all* children and students with special needs (AE1 LN 215-230). The representative noted that in grades 1 through 12, all education funding, including base instruction grants, severe disability funding, and mild-moderate funding, could be rolled together and used to serve all the students in a jurisdiction. It was not intended to be parceled out as funding per student (AE 1 LN 457-462). Initiatives were underway to allow the same pooling of early childhood funding.

Programming. When working with teachers in schools, the front-line SLPs grappled with their appropriate role in educational programming. They questioned the education community's support for their involvement, particularly in the areas of participation on student learning teams and development of individualized program plans. Local school authorities also appeared conflicted about the appropriate role for SLPs. When questioned about Alberta Education's position on these issues, their representative noted that expectations varied according to the needs of the child or students. In all cases, classroom teachers were expected to take a leadership role in identifying and advocating for the educational needs of their students, seeking assistance and strategies from relevant professionals. In more general language development cases, the ministry was reported to expect less direct involvement from a SLP with more consultative services seen as appropriate. For speech cases or more complex communication cases, more SLP involvement was thought to be optimal but the representative noted that "local conditions" are considered (AE1 LN 688-703). Specifically in terms of the learning team and individualized program plan (IPP) development, the representative noted that the classroom teacher would lead both but that "anyone who would have an interest or impact on that child's education program should be part of that learning team" (AE 1 LN 875-876) and that IPP goals should be written in terms of a child's functional needs in the classroom not clinical goals (AE1 LN 890-897). These expectations did not appear to be well understood or well met by either local speech-language services personnel or local education personnel.

Regional Consulting Services

The presence of a regional consulting program organized and funded by Alberta Education influenced local speech-language services. Although the speech-language part of the regional consulting service was designed to provide limited and specialized consultation to school teams serving students with severe communication disorders, their presence seemed to encourage the removal of health region services from these cases. As noted earlier in this chapter, at the time of the study, local speech-language services had instituted a process wherein children who qualified for the regional consulting service would not be seen, arguing that their resources would be best spent seeing children who did not receive the additional funding. They had reportedly allowed for some of the children to be re-referred back to their local services by a regional consulting service SLP if that clinician judged that direct intervention services were needed. Several participants voiced concerns about this process, wondering if families would understand and accept their refusal to continue service and the gap in service that would occur during the time between when the health region SLPs stopped serving their children and the time that the regional consulting service SLP was able to come out to consult. A school principal noted that the education community's concerns about the regional consulting service were not with the cost but rather with the accessibility of the service, in that the service was designed to provide very infrequent consultations to school staff which met their needs for some cases but not others. This principal was concerned about how school staff would manage to deal with some of the cases without the more regular assistance that had been available from the health region SLPs.

When discussing this situation with the regional consulting service coordinator and SLPs, it came evident that the local health region was not the only jurisdiction where teaming between the regional consulting service and the local health region staff became an issue. They emphasized that their service was not designed to provide ongoing, regular support to school teams nor was it designed to provide therapy services. While they reported that their service delivery model worked well for many of the severely multi-handicapped students on their caseloads, they needed partnerships with local health region services to address the needs of other children with speech disorders, fluency concerns, and hearing impairments. They also reported that local assistance would provide better service to students with social communication deficits and augmentative alternative communication needs. They spoke of the need to build relationships with individual local SLPs in order to meet the needs of students and of adjusting their expectations for collaboration based on the experience and caseloads of the local SLPs. They acknowledged that many health region SLPs were overburdened but drew attention to the fact that they also had large caseloads and that their cases were spread out over large geographical areas, making it nearly impossible for them to increase the frequency of their consultations. Parents were reported as refusing to sign consents for their children to be seen by the specialized consulting service out of fear that they would be denied local health region services. Interestingly, despite their apparent closer relationship with the educational community, the regional consulting service SLPs raised concerns about funding, accountability, time availability, and philosophical barriers to serving students with communication delays/disorders in the education system that were similar to those expressed by local health region SLPs. Most striking in the discussions about the regional consulting service was the sense that everyone involved in providing speech-language services for children felt overburdened and under siege and that decisions made on the basis of these feelings could very well prevent effective and efficient services for individual students. Once again, the services available to children were fragile in their dependence on the interpersonal relationships of the professionals involved.

Working in Two Worlds: A Hybrid Context

The investigation of the health context outlined a local work world largely caught up in responding defensively to outside demands on time and resources. Policies and practices were in conflict with each other and with the ideal role for SLPs providing services to school-age children. Although these conflicts were likely due to frequent organizational change and lack of an evidence base for decision-making, the effect was to constrain the work of front-line SLPs. The factors that facilitated front-line practice such as the supportive and flexible management system were not able to overcome negative influences such as high staffing turnover and the lack of a strategy for incorporating support personnel. The health ministry appeared unwilling or unable to take a leadership role in facilitating consistent speech-language pathology service delivery across the province through either funding or policy. This lack of influence was not understood on the front-line and the misunderstanding appeared to paralyze innovation in service delivery; as local service providers waited for government intervention that was not forthcoming. Health ministry initiatives that did influence speech-language pathology service delivery such as reorganization of health region boundaries and statistical collection and electronic health record systems were often disruptive of practice rather than facilitative. The needs of the service providers did not seem to be well understood or accommodated in the transition process. Finally, both local health region and provincial health ministry actions appeared to be incrementally contributing to increased interchangeability of SLPs and SLP assistants in service delivery.

The health context was not, of course, the only context where the front-line SLPs worked. When serving school-age children they spent the majority of their work time in the educational context. Locally, the educational context was one of multiple players with different expectations, needs, and resources. Education authorities were understandably focused on what they perceived as the educational needs of individual children and ameliorating communication difficulties that would interfere with that education. In their actions, however, they seemed to not fully recognize neither oral communication development as a part of a child's education nor their shared responsibility to promote it. They tended to focus more on identifying communication difficulties in individual children that were significant enough to qualify them for government special education funding and programming instead of on developing regular education programs that would facilitate all children's oral communication development. The needs of the speech-language services program and its providers and the demands on their time were not understood by educators and this sometimes resulted in the two entities working at cross-purposes. Indeed, educators did not have a clear understanding of the aspects of their own ministry's policies that influenced speech-language service provision. The education ministry, in their policies and in their support for regional educational consulting services, influenced speech-language services provided by health-employed SLPs yet they did not have a formal mechanism for negotiating this influence.

Trying to work in the hybrid work world formed by the health and education contexts clearly presented a major challenge to front-line SLPs and speech-language service provision, exacerbating the barriers front-line SLPs faced to achieving their perceived ideal role. S3 summarized the potential for conflicts between educators and the health-based speech-language service by stating, "We're managed by two different sets of rules and regulations and they're not always even on the same playing field and then we have different perspectives and different things that we're both trying to achieve (S3 R-SP-S Int 1 LN 2524-2527). Front-line SLPs typically attempted to negotiate this hybrid context by forging personal relationships with educators and school-by-school agreements about service provision. This negotiation required significant time and energy, interfered with their work satisfaction, and, most importantly, ultimately failed to guarantee any particular level of service to children in need.

Working Together: Negotiating a Shared Context

Management personnel within both health and education were not unaware of the challenges their different contexts posed to the delivery of speech-language services. For example, the regional manager for speech-language services described the situation as "two very different systems and philosophies colliding" (MSLP Int 2 LN 230-231). The coordinator for the regional education consulting teams stated that, "If I were the queen, there would be one ministry and one ministry only and it would be 'kids' services' and nobody belongs in Health and nobody belongs in Education and we'd finally have people come together" (CRT Int LN 650-653).

While an actual merging of ministries is unlikely, my study has reaffirmed the importance of Health and Education working together to improve speech-language services for school-age children that had been previously acknowledged in Canada (Alexander, 1986; Sutherland, 1992). The front-line SLPs in my study strongly recognized this need for collaboration. Recognition of the important of partnerships appeared to be increasing within Alberta institutions at the time of my research. Student Health Initiative Partnerships (SHIPs), a government initiative designed to bring local health and education stakeholders together, had been operating for several years. Speech-language services had been identified as a priority by SHIPs throughout the province since their inception (Student Health Initiative, 2005). While these partnerships were reported to have improved dialogue and planning among stakeholders, the partnerships were plagued by concerns about sustainability as a result of limited and somewhat uncertain funding.

A July 2003 review of the Student Health Initiative ultimately led to a provincial review of speech-language services. The review, which was underway at the time of my study, was conducted under the auspices of the Alberta Child and Youth Initiative and brought together the education, advanced education, health, and community services ministries and various professional and community representatives. When interviewed, Alberta Education's representative on the review suggested to me that one of the most useful aspects of the review was the simple opportunity for dialogue among professions about various concerns. This dialogue was reported to have resulted in new understandings for participants in the review process. The representative noted that a literature review and a survey of other provincial systems were conducted in the initial stages of the review but that no particular model had been identified which could be adopted to resolve the issues (AE3 LN 520-525). When questioned about the potential for new funding coming out of the review, the representative noted that the review was not about increased funding, but was rather about changing *how* services are provided (AE2 LN 556-560).

By the conclusion of my study, the review was completed but there was only preliminary indication that changes in service provision would simply be *encouraged* by government facilitation of information sharing among service agencies and providers. The formal report of the Review of Speech-Language Services for Children and Youth in Alberta was released by the Alberta Children and Youth Initiative in late 2006 despite a publication date in 2005. The report specified goals and strategies to address seven different issues but did not specify particular actions to be undertaken by particular organizations or government agencies nor include any recommendations for increased or protected funding (Alberta Children and Youth Initiative, 2005).

While both the Student Health Initiative Partnerships and the Review of Speech-Language Services for Children and Youth were positive undertakings, they did not seem to have the potential to enable front-line service providers in health and education to negotiate a shared context. There appeared to be one initiative on the horizon, however, with the potential to enable front-line service providers to negotiate a shared context. During my study I became aware that representatives of Alberta Education were working with representatives of local school districts, health regions, and Child and Family Services to initiate a pilot project addressing integrated, coordinated services for children with special needs. The idea was that each agency would offer the resources they would typically provide to the pilot school site but would allow these resources to be pooled with those of other agencies to serve the needs of the children at that school site. The Alberta Education representative I interviewed noted that one of the goals of the proposed pilot was to reduce the anxiety of local administrators and front-line service providers about preserving their agency's mandate and to invoke systemic change that would free front-line providers to collaborate to meet needs efficiently and effectively AE4 LN 180-185). The results of my study supported the critical need for exactly this type of government- and management-supported systemic change in the work context of front-line SLPs.

CHAPTER EIGHT: CONCLUSIONS AND FUTURE DIRECTIONS

"They kept saying, 'But we're just so busy,' and I said, 'Listen, we can't keep giving that mantra. There will never be enough resources for the needs out there. That's common ground so let's get that out of the way now'." (CRT Int LN 615-617)

Ensuring adequate speech-language services for the significant numbers of school-age children who require this assistance to enable them to meet their academic and social potential is a critical issue in Canada. As a predominantly public service, which crosses government ministerial mandates, speech-language services have raised challenging policy questions across provinces. When turned to for guidance in answering these policy questions, Canadian SLPs have not been able to reference service delivery research specific to their unique context. My study was designed to help fill this gap.

I selected a health region in Alberta as an example of an organizational system responsible for providing speech-language services to school-age children in Canada. I used the theories, philosophies, and methods of institutional ethnography to investigate speech-language service provision in this system with two objectives. The first was to develop a detailed description of the work of front-line SLPs including an examination of their perceived ideal work role and their currently practiced work role. My second objective was to explicate the influence of organizational and governmental policies on front-line practice. The findings and implications are summarized in the following sections.

Summary of Findings

Fourteen front-line SLPs participated in the first stage of the study. Interviews and observations were directed at discovering the participants' perceived ideal roles and currently practiced roles. Data were analyzed, interpreted and summarized into key findings in each of these two areas.

Perceived Ideal Role

1. Two perspectives on the ideal role emerged: specific and task-oriented perspective and an overarching and philosophical perspective.
2. The specific and task-oriented perspective consisted of "things to do" in the best possible practice and included the following goals:
    a. Provide a spectrum of service in a timely manner

   b. Promote appropriate identification and diagnosis
   c. Provide most appropriate intervention to each child
   d. Provide timely service
   e. Work with others to achieve outcomes for children, including support personnel, school staff, and families
   f. Learn and reflect to improve practice

   Participants' goals in this perspective all related to working with others to provide appropriate and timely speech-language services to school-age children. "Appropriate" related both to consideration of the unique needs of individual clients and to providing services that were revised to incorporate the new learning and ongoing reflections of the SLPs. A high valuing of face-to-face interventions with clients, as well as families and school staff, was noted.

3. The overarching and philosophical perspective described a variety of concepts seen by participants as foundational to best possible practice and included the following goals:
   a. One school per SLP
   b. Employment in education
   c. Reflect professional expertise in service and promote a support environment
   d. Expand service focus to contribute to developing language-learning environments and literacy
   e. Serve a moral purpose

   Participants' seemingly disparate goals in this perspective converged to portray their dream for a profession with a unique and ethical purpose tied to developing the communication skills of clients and achieved through professional participation in client contexts, specifically the education context for school-age children.

4. Ultimately, the specific and task-oriented and overarching and philosophical perspectives came together to reveal a truth about front-line practice in that it requires both macro- and micro-management, that is, taking a more global view

of services to be provided as well as attending to the specifics of day-to-day practice.

5. Two overall themes emerged from the data on the perceived ideal role. The first was a strong ethical service orientation to doing "what was best" for clients by determining their unique needs and providing services to specifically address those needs. The second was a certain amount of ambiguity about their professional role. No participant was able to reconcile the need for both global considerations of service delivery and considerations focused on individual clients.
6. Discord apparent between the two identified themes of doing "what was best" and ambiguity about how to achieve that goal harkened back to a potential conflict between perceived ideal work role and currently practiced work role ascertained in the literature review and raised questions about if and how this discord would be revealed in current practice.

Currently Practiced Role

1. Two main components of the SLP participants' currently practiced role were identified:
    a. Client-Focused – activities and understandings necessary for serving individual students, and
    b. Service-Focused – activities and understandings related to the service delivery system as a whole.

   A tentative third component consisting of activities and understandings related to influencing the overall environment in the schools and in the broader community was not fully supported by the data.
2. The current role of front-line SLPs was dominated by a dual focus on managing the large numbers of clients and on allocating the finite staff time available to address their needs. Front-line SLPs spent significant amounts of time on caseload management and scheduling activities and supervising support personnel.
3. The two themes identified within the perceived ideal role of participants were evident in their current practice.

   a. Personal and service orientations to the ideal of "doing what was best" for individual clients could not be actualized in practice due in large part to the sheer number of clients and service sites to address within the limited staff time available. These barriers led to rationing of services with dubious results.
   b. Participants struggled to reconcile the need for both global considerations of service delivery and considerations focused on individual clients.
   c. Discord between the two themes was evident in practice and revealed itself in the daily struggle of participants to manage their caseload within the service time available.
4. Participating SLPs were unable to achieve their perceived ideal practice in their current circumstances.
   a. The sheer number of clients and sites requiring service appeared to largely overwhelm the service's capacity for timely, collaborative, needs-based practice and largely prevented SLPs from promoting supportive language-learning environments.
   b. The pressures of large caseloads and limited service time also appeared to distance the front-line SLPs from those they had wished to support – teacher and parents, and even the children they served.
   c. The availability of support personnel to assist front-line SLPs in providing service actually appeared to further shift services away from the ideal practice perceived by the SLPs.
5. Significant role conflict was evident because the participants' current practice did not reflect their perceived ideal. This role conflict jeopardized their work satisfaction and even their ability to practice ethically.
6. An influence of organizational and governmental context on the work of front-line SLPs was evident, but required further exploration.

Influence of Organization and Government Contexts

The organization and government context for the provision of speech-language services by the front-line SLP participants was investigated in stage two of my study. Data from interviews with administrators in the local health region, the education ministry (Alberta Education), and the health ministry (Alberta Health and Wellness) were analyzed and summarized as follows:

1. The work of front-line SLP participants was significantly influenced by factors beyond their immediate control, including:
    a. The local health region's management structure, philosophy, and style, staffing plan and clinician placements, and policies related to caseload management, negotiating the school setting, and documentation.
    b. Alberta Health and Wellness decisions related to health region organization, funding and mandate, provincial coordination, and record-keeping.
    c. The multiple players, special needs initiatives, communication channels, and understanding and accommodation of speech-language services within the local education scene.
    d. Alberta Education decisions related to special education policies and regional consulting services significantly influenced the work of SLP participants.
2. Within the health context, the participating SLPs' local work world was largely, and understandably, caught up in responding defensively to outside demands on finite time and resources. Alberta Health and Wellness appeared unwilling or unable to take a leadership role in facilitating consistent speech-language pathology service delivery across the province either through funding or policy.
3. Within the education context, the participating SLPs' local work world was one of multiple players with different expectations, needs, and resources. Educators did not exhibit a clear understanding of the needs of the speech-language services program and its providers and the demands on their time or the aspects of their own ministry's policies and practices that influenced speech-language service provision. Alberta Education did not have a formal mechanism for negotiating this influence.
4. Participating SLPs practiced in a hybrid work world formed by the health and education contexts, which was far from the shared context they envisioned for their ideal role. Their attempts to negotiate the hybrid context by forging personal

relationships with education and school-by-school agreements about service provision required significant time and energy, interfered with their work satisfaction, and, most importantly, ultimately failed to guarantee any particular level of service for school-age children.

5. Management personnel within both health and education demonstrated awareness of the challenges their different contexts posed to the delivery of speech-language services. The administrative changes which had occurred, however, did not appear to have the potential to enable front-line service providers in health and education to negotiate a shared context.
6. Preliminary discussions about an inter-ministerial/inter-organizational pilot project addressing speech-language service delivery for school-age children appeared more promising for facilitating the necessary systemic change.

While my study revealed numerous significant issues in the delivery of speech-language services to school-age children within the study region, there were also many signs of hope. The front-line SLPs were able to eloquently express a vision for their ideal role; one that brought together such elements as evidence-based practice, interpersonal sensitivity, and moral, ethical conduct. Through their extraordinary efforts, they were able to facilitate and celebrate many successes for the young children on their caseloads. These clinicians, along with their management team, were dedicated to improving their provision of speech-language services. The educators, administrators, consulting team members, and the representatives of the Alberta government ministries of health and education were also all keenly interested in how speech-language services were provided and wanted to learn more about how services could be improved.

Implications of Findings

The ultimate aim of my research was to identify and clarify issues related to the provision of speech-language services to school-age children that would not only provide practice and policy guidance locally but would also be relevant to front-line SLPs, administrators, professional training institutions, policy makers, and researchers provincially and nationally. Although my study was conducted in a single health region in Alberta, the front-line practice situation and the associated conflicts were not likely that different from those in other Canadian work settings. The literature review demonstrated that many Canadian SLPs served school-age children in a similar hybrid context. Even SLPs who were employed by education authorities in other provinces were found to face the same issues of large numbers of clients and limited service time. Indeed, Burnett (2003) affirmed that regardless of where they were employed, rehabilitation therapists, including SLPs, struggled to direct their own practice within organizational controls and resource limitations. What, then, are the main implications of my findings?

First, SLPs working with school-age children in Canada and their management teams require research and administrative guidance to enable them to reconcile global service delivery concerns with considerations focused on the needs of individual clients. This research and guidance must be grounded in the immediate practice context. For example, speech-language services in American schools are influenced by federal and state special education regulations. These regulations often dictate the types of students that are on the caseloads of American school-based SLPs. These regulations are not in place in Canada and, as a result, "eligibility" for speech-language services is often more broad and locally determined.

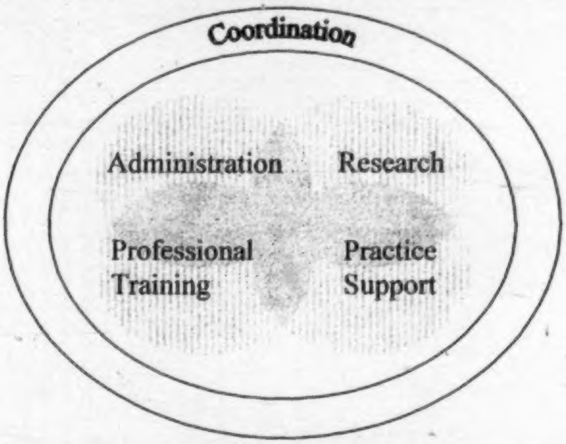
Secondly, caseload management and supervisory duties undertaken by front-line SLPs must be carefully reconsidered and monitored as the time required to accomplish these duties is a barrier to their perceived ideal practice and threatens the efficiency and effectiveness of the overall service delivery system. A critical need for system designs that would enable the delivery of evidence-based, quality services exists. Quality service must be defined by research, entrenched in policy and practice, and protected against organizational and demographic pressures to provide "quantity services".

Finally, conflicts between health and education contexts must be reconciled to remove barriers to the delivery of speech-language services to children. Reconciling these conflicts will also help to ensure optimal use of the available resources.

Moving Forward: Taking Action to Address the Implications

My study's implications converge to emphasize a need to re-vision and restructure speech-language services for school-age children to better fit the Canadian context. Systemic change is required. Resources must therefore not be allowed to dominate discussions about the renewal of these services. As stated in the quote at the beginning of this chapter, we need to 'get that out of the way now', but where *do* we start? Some might focus on trying to determine which government ministry should bear ultimate responsibility for speech-language service delivery. My literature review demonstrated, however, that such determinations have already been attempted but yielded few or no service improvements. I contend that a better first step is to identify specific actions that can be taken by the key constituents: front-line clinicians, administrators, professional training institutions, professional colleges and associations, policy makers, and the research community. Some of the actions are specific to the Alberta context and these are not inconsistent with the strategies arising from the recent review of speech-language services (Alberta Children and Youth Initiative, 2005) although they are more specific in nature. The majority of the suggested actions are national in scope. There are four main areas to which these actions relate: administration, research, professional training, and, practice support. As illustrated in Figure 3, actions in these areas are inter-related, codependent and require overall coordination.

Figure 3: Action Areas to Re-vision and Restructure Speech-Language Services



Administration

Within the area of administration, local employing organizations and provincial governments must both take action. My study demonstrated that each level of administration significantly influences front-line SLP practice with school-age children.

All Local Employers

Any local organization that employs SLPs working with school-age children can take immediate action in the following ways:

1. Facilitate awareness, among members of the speech-language services management team, of the history of speech-language services provision locally, provincially, and nationally and current practice issues to ensure that the front-line SLPs have access to the support which they require.
2. Work, in conjunction with provincial and federal counterparts, to develop and evaluate new human resource strategies and staffing models to better address the provision of speech-language services. This work should attend to the need for an appropriate mix of professional and paraprofessional staff, for appropriate administrative support to ensure front-line service providers focus on serving clients, and for part-time and flex-time arrangements to meet the needs of a predominantly female workforce and to accommodate the vagaries of the school year schedule.
3. Clarify service priorities through discussion with front-line SLPs and analysis of the research literature to determine evidence-based practices. Revise policies and practices to be consistent with the identified priorities.
4. Review the use of support personnel to ensure that SLPs maintain an ability to both provide a spectrum of services and supervise support personnel appropriately. Consider the influence of the timeline for service provision in schools and determine administrative tasks that support personnel can perform without supervision.
5. Protect client-service time by judiciously using front-line SLP time for service-focused activities. Strategize with clinicians to find efficiencies and provide appropriate levels of clerical support.
6. Provide appropriate access to technological support. Each SLP should have access to a computer (laptop for itinerant clinicians) to expedite preparation of needed documentation, provide ready access to reference materials, and employ as an assessment and treatment tool.
7. Support learning. Build protected SLP office time into service strategies and fund professional development activities.
8. Analyze how placement characteristics influence practice. Adopt and evaluate means of supporting rural clinicians such as mentoring initiatives.

9. Support practice-based research. Work with organizational research department if available, and/or develop partnerships with researchers at universities. Facilitate research participation by front-line clinicians and management teams. Include an evaluation component in all service delivery plans.

Employers in Hybrid Health/Education Contexts

My study demonstrated that in hybrid health/education work contexts, local health and education organizations must come together to develop a shared context for speech-language service delivery. Partnerships between organizations must be created, or further developed, to focus jointly on re-visioning and restructuring speech-language services for school-age children. The following actions can increase the likelihood of successful partnerships:

1. Share information on needs, resources and allocation. For example, health organizations could share demographic information demonstrating both the percentage of the local population that is school-age and the percentage of overall speech-language service human resources dedicated to meeting the needs of that population. Education authorities could share demographic information demonstrating the percentage of their student populations identified as having various special needs and the allocation of educational assistants.
2. Work together to identify and meet learning needs. For example, health SLPs could provide in-services to teachers to help them understand local speech-language services, the role of SLPs and of support personnel, and how to collaborate with SLPs to serve their students. Educators could provide in-services to health SLPs about local regular and special education initiatives.
3. Improve ongoing communication about speech-language service delivery both within organizations and among front-line SLPs and educators. For example, utilize methods of intra-organizational communication already in place to highlight information on health-education partnerships for speech-language services. Partnerships could also formalize a key contact person for health SLPs in each school.

4. Identify and pursue opportunities for pilot projects. For example, joint service teams between health SLPs and regular and special educators could be piloted at select sites and evaluated for potential use elsewhere.

Government

Government policy makers must carefully consider how the policies they create and the practices they support influence front-line SLP practice with school-age children. Policies and practices which pose barriers to efficient and effective practice should be altered. To illustrate this point, within the context of my study the provincial ministries of health and education and inter-ministerial partnerships could each take action to re-vision and restructure speech-language service delivery.

1. Alberta Health and Wellness could take action to:
    a. Tie funding to outcomes. Reconsider the global funding policy to investigate providing specific envelopes of funding for targeted services, alternatively or in combination with researching and mandating specific service benchmarks.
    b. Address service inconsistencies across the province. In keeping with a ministry focus on knowledge brokering for health, retain a provincial consultant for speech-language and audiology services to facilitate projects to improve services across health regions and information sharing initiatives.
    c. Improve nature and method of collection of statistical information related to service delivery. Investigate means of reducing the time burden on front-line SLPs. Improve consultation with rehabilitation and speech-language service managers and front-line clinicians aimed at ensuring that useful statistical reports were available to those charged with local decision-making about services.
    d. Lead development of health human resource planning for rehabilitation services, including speech-language pathology, by facilitating application of the Comprehensive Health Workforce Plan (Alberta Health and Wellness, 2003).

2. Alberta Education could take action to:
    a. Increase consultation with speech-language service providers in order to better ascertain the influence of special education coding and funding policies and practices on the provision of speech-language services to school-age children and develop and test means of negotiating this influence.
    b. Recognize the key role of SLPs in learning and education by highlighting this role in special education guidelines, by funding the development of technical assistance documents for educator/SLP collaboration, and by sponsoring joint professional development opportunities for educators and SLPs.
    c. Clarify the role of educational assistants in Alberta public schools, including their utilization as support personnel for SLPs.
    d. Emphasize with Alberta Infrastructure the importance of considering the need for small spaces suitable for use by visiting clinicians when building and renovating schools.
3. Inter-ministerial partnerships are critical due to the joint ministerial interest in speech-language service delivery outcomes. Partnerships could take action to:
    a. Coordinate and fund pilot projects to test innovations in speech-language service delivery for different populations, including school-age children.
    b. Develop a comprehensive plan to address the need for health and other services within schools as acknowledged in the literature on full service schools (Dryfoos & Maguire, 2002; Kronick, 2002).

Research

Canadians interested in the provision of speech-language services cannot continue to rely on American practice literature. Instead we must develop our own reasoned response to our uniquely Canadian context. To assist with the re-visioning and restructuring of speech-language services for school-age children, the Canadian research community can take the following actions:

1. Fund and conduct research to increase the evidence base for practice techniques commonly used in Canada, particularly in the areas of collaborative school service, block scheduling, use of support personnel, and telepractice.
2. Fund and conduct treatment outcomes research highlighting issues of particular interest to SLPs serving school-age children such as outcomes achieved by different populations when service is facilitated by different agents of change, including support personnel and classroom teachers.
3. Fund and conduct research to ascertain the value of health promotion activities in the area of speech and language development.
4. Fund and conduct systematic reviews of issues relevant to front-line SLPs, utilizing such established resources as the Canadian Cochrane Network and Centre, the Cochrane Child Health Field, and the Canadian Centre for Knowledge Mobilisation.
5. Facilitate consideration of global practice research, such as British practice research, which may be more applicable to the Canadian context than American research.
6. Formally encourage researcher-clinician partnerships to ensure that the research is grounded in the immediate practice context.
7. Utilize the Canadian Language and Literacy Research Network to promote knowledge creation and exchange among researchers, SLPs, and educators, and policy makers.
8. Apply open access principles (Willinsky, 2006) to remove barriers to accessing research information for front-line clinicians.

Professional Training

Institutions that provide SLPs with their professional training can contribute to a re-visioning and restructuring of speech-language services for school-age children by better preparing their students for Canadian practice realities. To that end, they can take the following actions:

1. Acknowledge that school practice requires an entire subset of specialized practice knowledge by developing a specific course to address that knowledge.

2. Teach students about educational and health reforms and help them to analyze issues arising from these reforms.
3. Work with practicum supervisors to provide students with opportunities to experience working in ways that more closely resemble front-line school practice, including working with support personnel.
4. Explore collaborative partnerships with education faculties to provide education and speech-language pathology students with joint coursework and practicum opportunities.
5. Provide students with opportunities to engage in meaningful discussions about ethical practice, including challenges to ethical practice posed by work contexts.
6. Develop student ability to find and apply research evidence to actual practice questions.
7. Support university researcher-clinician partnerships to further knowledge about Canadian practice.

There is also a need to engage training programs for SLP assistants in the re-visioning and restructuring process. As our knowledge about the most effective and efficient ways to include paraprofessionals in speech-language service delivery develops, adjustments to training programs will be needed. We also need to learn from the experiences of graduates of these programs and the SLPs who teach in them.

Practice Support

Canadian professional colleges and associations can fulfill an important leadership role in the provision of practice support to front-line SLPs. The Canadian Association of Speech-Language Pathologists and Audiologists (CASLPA) has an important role on the national level. Alliances among CASLPA and provincial colleges and associations have been developed and could be utilized to carry out the following recommended actions:

1. Increase the knowledge base about SLP practice by commissioning national practice surveys, designed in collaboration with both researchers and front-line clinicians.
2. Develop position statements and technical assistance documents specific to school practice issues such as the appropriate school facilities, developing educationally-

relevant IEPs and working for organizational change topics explored by the American Speech-Language-Hearing Association (ASHA, 2000b, 2000c, 2002e).

3. Lead in the development of a coordinated national plan for the appropriate use and supervision of SLP assistants with an emphasis on the need to preserve the role of fully qualified SLPs in the service delivery system (Paul-Brown & Goldberg, 2001).
4. Engage in ongoing renewal of practice standards to adequately address non-clinical areas such as the use of support personnel
5. Continue development of practice guidelines as these documents form an important part of the link between research and practice for all SLPs.
6. Recognize systems-related influences on practice and the competence displayed by SLPs by discussing these influences in standards and guidelines documents and encouraging SLPs to formally consider these influences by including them in continuing competence programs.
7. Lead development of a web-based service to provide evidence-based answers to everyday practice questions, using *Practice-based Evidence in Nutrition (PEN)* by the Dietitians of Canada as an example (Corby & Thirsk, 2007).
8. Provide or sponsor a wide-range of continuing professional development activities, including non-traditional activities such as internet forums and mentoring initiatives and non-clinical topics such as supervision and ethical dimensions of clinical work.

Coordination

Coordination of the actions within and across the areas of administration, research, professional training, and practice support is necessary to achieve the maximum positive influence on front-line practice with the resources available within each area. I have identified two potential mechanisms for achieving this coordination.

The first is the formation of a national coordinating council for speech-language pathology and audiology. A need to bring those responsible for professional training together with those responsible for regulating and supporting practice has already been identified. In late April 2007, representatives from university training programs are scheduled to meet with representatives of CASLPA and provincial colleges and associations. It may very well be possible to build on this beginning to develop a national body that would include additional representation from the research community and from administrators and policy makers.

The Canadian Language and Literacy Research Network (CLLRNet) could also reasonably play a role in coordinating and facilitating many of the research and practice support activities specific to the school-age population. The network's vision is directed towards the improvement of language and literacy skills in Canadian children through the creation of an integrated network of researchers, practitioners and government policy makers. Goals of the network relate to measuring the efficacy of conventional practice in the field and promoting evidence-based practice and policies (Canadian Language and Literacy Research Network, 2007). A potential coordinating activity for CLLRNet could be the establishment of a resource website specific to SLP practice in Canadian schools, similar to the National Center for Speech-Language Pathology in Schools' function for American practice (Creaghead et al., 2004). This website could serve as a pan-Canadian entry point for open access to research-based information about the practice of speech-language pathology in Canada (Willinsky, 2006), live-streaming of professional development sessions, and as a venue for sharing among front-line clinicians.

These two potential mechanisms need not be mutually exclusive. Indeed, the complexity of the coordination involved may result in the need for coordinating organizations that collaborate but focus on different types of activities. Speech-language pathology is also a small profession, which often results in the need to coordinate with other rehabilitation professions on certain initiatives.

Final Word

The constituents and coordinating organizations must always retain a focus on their primary clients: school-age children and their families. When planning and executing any of the identified actions, the wishes of parents of children with communication disorders and the potential impact of our actions on their lives and those of their children must be considered carefully. We need to develop more mechanisms for parental involvement in decision-making, from satisfaction surveys to formal representation on planning committees.

There is also a need to engage communities across Canada in the promotion of environments that facilitate language, literacy, and communication development. As has been said of the mental health field, in speech-language services "there will never be enough therapists, we need therapeutic communities" (Rafaat & Wotherspoon, 2006).

Fulfillment of this action plan would help to develop and realize a vision for how to best meet the speech-language service needs of school-age children and how to best utilize the specific skills of SLPs, support personnel, other professionals, and parents to do so. Many of the actions recommended are not specific to school-age service. Therefore, completion would benefit all speech-language pathology services in Canada.

Execution of this action plan will take leadership. While leadership by administrators, policy makers, researchers, professional training institutions, professional colleges and associations is critical, it can only support the leadership that must be shown by front-line SLPs themselves.

To "profess" means to stand up for what you do (Leir, 2006). I am proud to be a member of the speech-language pathology profession, despite the struggles illuminated in my study. This thesis began with a description of a pivotal moment in my consideration of Canadian speech-language services when I had to literally stand up at an American convention according to the size of my Canadian caseload. I believe there are many Canadian SLPs standing up for their school-age practice alone and with some uncertainty. As responsible professionals, we must take action to develop a research base and engage in ongoing professional discourse to achieve the goal of creating, understanding, implementing, and evaluating an evidence-based paradigm of what it means to be an excellent practitioner with school-age children in Canada.

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Appendix A: Work Tasks of Speech-Language Pathologists

This appendix contains two different listings of the tasks of speech-language pathologists obtained during the literature review. The first is a Canadian example while the second provides information from the United States.

Lafargue and Vowels' Speech-Language Pathology Work Categories

In 1985, Lafargue and Vowels reported on the workload evaluation for a speech-language pathologist (SLP) providing service to patients of a health region in central Newfoundland. The first phase of their study identified the types of tasks conducted by the SLP and clustered those tasks into four major categories of duties as listed below. Note that the percentages of time the participating SLP spent on each of the major categories have been provided in brackets.

1. Direct patient contact (37% of time)
    a. Initial evaluation
    b. Recheck evaluation
    c. Therapy
2. Non-direct-contact patient-related work (34% of time)
    a. Preparation for therapy
    b. Review of tapes
    c. Home program preparation
    d. Counselling (parents, professionals, etc.)
    e. Report writing
    f. Correspondence about patient
3. Departmental work (19% of time)
    a. Scheduling
    b. Statistics
    c. Public relations
    d. Departmental meeting
    e. Committee work
    f. Correspondence/phone (administration related)
    g. Travel time
4. Education and professional development (10% of time)
    a. Preparation for inservice/workshops
    b. Giving inservices/workshops
    c. Attending educational functions
    d. Professional association(s) involvement
    e. Student supervision
    f. General organization (Larfargue & Vowels, 1985, p. 34)

Core Roles and Responsibilities of School-based Speech-Language Pathologists in the United States

In 1999, the American Speech-Language-Hearing Association (ASHA) published *Guidelines for the Roles and Responsibilities of the School-Based Speech-Language Pathologist*. The document contained a consensus opinion that the following roles and responsibilities were central to the practice of speech-language pathology in American schools.

1. Prevention
    a. Inservice Training
    b. Consultation
2. Identification
    a. Prereferral Interventions
    b. Screening: Hearing, Speech, and Language
    c. Referral and Consent for Evaluation
3. Assessment (Data Collection)
    a. Assessment Plan
    b. Assessment Methods
        i. Student History
        ii. Nonstandardized Assessment
        iii. Standardized Assessment
4. Evaluation (Interpretation)
    a. Strengths/Needs/Emerging Abilities
    b. Disorder/Delay/Difference
    c. Severity Rating
    d. Educational Relevance: Academic, Social-Emotional, and Vocational Factors
    e. Evaluation Results and Team Recommendations
    f. Specific Evaluation Considerations
        i. Age
        ii. Attention
        iii. Central Auditory Processing
        iv. Cognitive Factors
        v. Cultural and/or Linguistic Diversity/Limited English Proficiency
        vi. Hearing Loss and Deafness
        vii. Neurologic, Orthopedic, ad Other Health Factors
        viii. Social-Emotional Factors
5. Eligibility Determination
    a. Federal Mandates, State Regulations/Guidelines, and Local Policies/Procedures
    b. Presence of Disorder
    c. Educational Relevance
    d. Other Factors

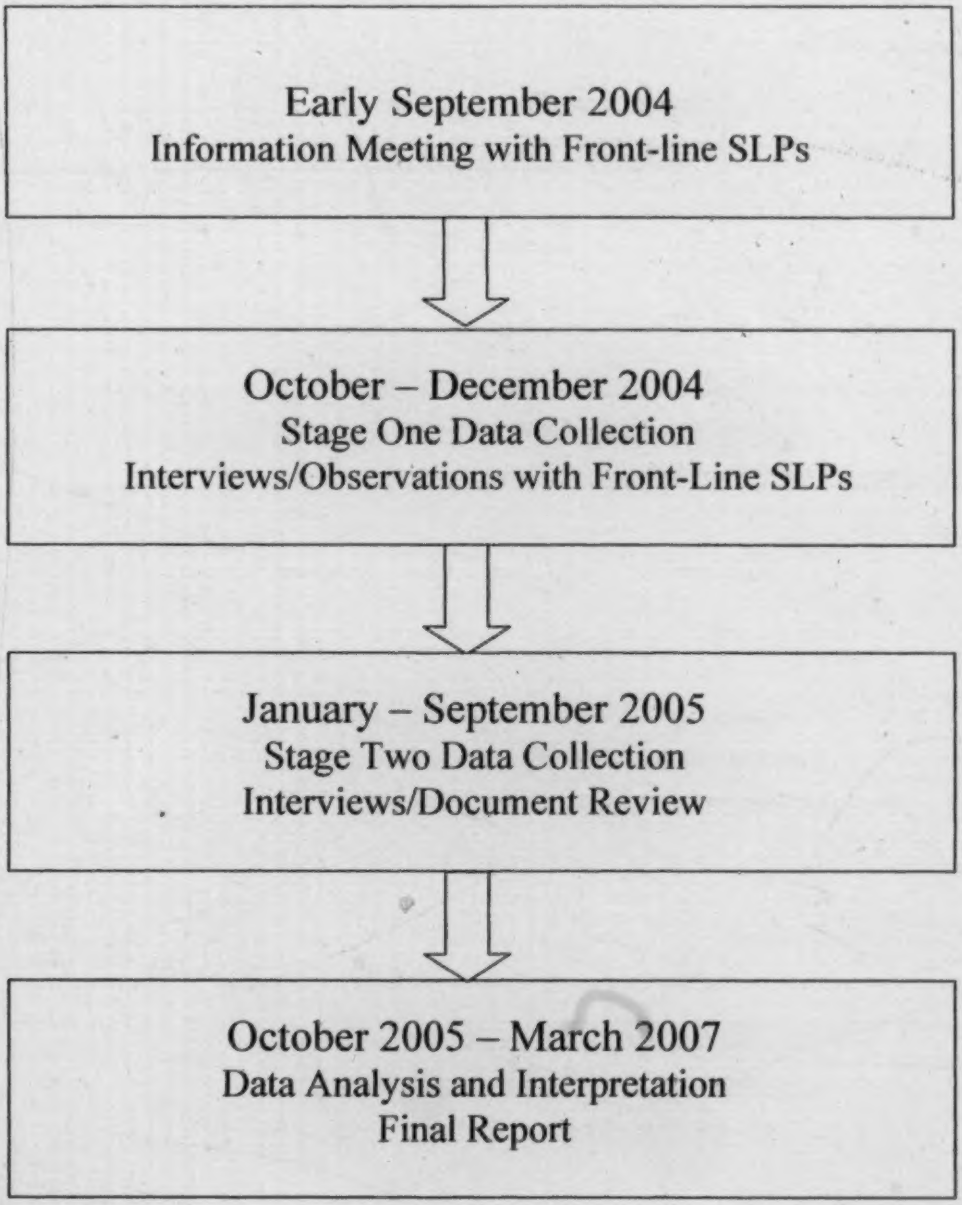
6. Individualized Education Plan (IEP) Development
    a. Federal Mandates, State Regulations/Guidelines, and Local Policies/Procedures
    b. IEP Team
    c. Factors
    d. Components
    e. Caseload Size
7. Caseload Management
    a. Coordination of Program
    b. Service Delivery Options
    c. Scheduling Students for Intervention
    d. Caseload Size
8. Intervention
    a. For Communication Disorders
        i. General Intervention Methods
        ii. Scope of Intervention
            1. Communication
            2. Language
            3. Speech: Articulation/Phonology, Fluency, Voice/Resonance
            4. Swallowing
    b. For Communication Variations
        i. Cultural and/or Linguistic Diversity
        ii. Limited English Proficiency
        iii. Student Requiring Technology Support
9. Counseling
    a. Goal Setting and Purpose
    b. Referral
10. Re-Evaluation
    a. Triennial
    b. Annual
    c. Ongoing
11. Transition
    a. Between levels (birth to 3, preschool, elementary, secondary)
    b. Secondary to post-secondary education or employment
    c. More-restrictive to less-restrictive settings
12. Dismissal
    a. Federal Mandates, State Regulations/Guidelines, and Local Policies/Procedures
    b. Presence of Disorder
    c. Educational Relevance
    d. Other Factors
13. Supervision
    a. Clinical Fellows
    b. Support Personnel
    c. University Practicum Students

Supervision continued

  d. Volunteers

14. Documentation and Accountability
    a. Federal Mandates, State Regulations/Guidelines, and Local Policies/Procedures
    b. Progress Reports
    c. Third-Party Documentation
    d. Treatment Outcome Measures
    e. Performance Appraisal
    f. Risk Management (ASHA, 1999, pp. 14-15)

Appendix B: Study Flowchart


Early September 2004
Information Meeting with Front-line SLPs
October – December 2004
Stage One Data Collection
Interviews/Observations with Front-Line SLPs
January – September 2005
Stage Two Data Collection
Interviews/Document Review
October 2005 – March 2007
Data Analysis and Interpretation
Final Report

Appendix C: Information Letters and Consent Forms

SLP Information Letter and Consent Form 245
Stage One Informal Interview Information Letter and Consent Form . . 249
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SLP Information Letter

Date of Letter Release

Dear (SLP),

I am writing to ask for your consent to participate in my study on the provision of speech-language services to school-age children. The research is for my dissertation as a doctoral student in the Department of Elementary Education at the University of Alberta. The purpose of this study is to develop a detailed description of the work of front-line speech-language pathologists and to determine the influence of organization and government policies on front-line practice. In addition to completing my dissertation, I will also be using the information in presentations and publications.

Your participation in the study will include participating in an initial interview, allowing me to observe you as you conduct the standard tasks of your workplace, and participating in a follow-up interview. The interview and observation sessions will be conducted at your convenience. In the initial interview, you will be asked to share your views of your role in working with school-age children in the health region and to describe your different work tasks. The interview session will take no longer than one hour. The observation sessions will be coordinated for all participants at a site to allow me to observe each different task conducted by SLPs in that workplace. The purpose of these observations is to develop my understanding of your workplace tasks and the role of organization and government policy in these tasks. An attempt will be made to balance the number and length of observations across participants at a site. I will stay at one site no longer than three weeks and I will make written notes of my observations. During my time on-site, I will conduct a cursory review of client files to observe how the paperwork within the files documents your work process and reflects organization and/or government policies influencing your work. No information specific to individual students will be used in the research. After the observations are completed, you will be asked to participate in a follow-up interview, again for no longer than one hour. In this interview I will clarify information obtained in the first interview and from the observation. I will be audiotaping all interviews, as this is essential for accuracy. The tapes will be transcribed and the information will be analyzed in conjunction with information collected in stage two of the study. In stage two, I will be interviewing health administrators, teacher and school administrators, provincial government employees, and other relevant individuals as selected for their presumed ability to answer specific questions raised in the first stage of data collection about the influence of organization and government policies on front-line SLP practice.

Your participation in the study will be voluntary and you are able to withdraw at any time. I will not conceal any information from the participants. All information gathered will be treated confidentially. The findings from the study will be included in my dissertation and disseminated in scholarly and professional journals, books, conferences, and workshops. In these documents and presentations you will not be identifiable. All original data will retained in a secure venue for a period of five years and then destroyed.

The plan for the study has been reviewed for its adherence to ethical guidelines and approved by the Faculties of Education and Extension Research Ethics Board (EEREB) at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Chair of the EEREB at 780-492-3751.

Please complete the attached consent form to indicate whether or not you would be willing to participate in the any of the research activities planned and forward the form to me according to our agreed upon plan. I will contact you shortly after the signing of this form to arrange a mutually convenient time for the initial interview.

Questions or concerns regarding this study can be directed to me, Heather Sample Gosse (780-416-1082) or my supervisor, Dr. Linda Phillips (780-492-4250). You may also wish to contact the chair of the Department of Elementary Education, Dr. Dianne Oberg (780-492-4273). I look forward to working with you throughout the duration of the study.

Sincerely,

Heather Sample Gosse M.Sc. R.SLP
Doctoral Student
Department of Elementary Education

SLP Consent Form

Title:	A Study of Speech-Language Pathology Services for School-Age Children in Alberta
Student Researcher:	Heather Sample Gosse R.SLP, Doctoral Student, Elementary Education. Phone: 780-416-1082
Supervisor:	Dr. Linda Phillips, Centre for Research on Literacy Phone: 780-492-4250
Purpose:	The purpose of this study is to develop a detailed description of the work of front-line speech-language pathologists and to determine the influence of organization and government policies on front-line practice. My participation in the study will include participating in an initial interview, allowing the researcher to observe me conduct standard workplace tasks, and participating in a follow-up interview. The interview and observation sessions will be conducted at my convenience. The initial interview session will take no longer than one hour and I will be asked to share my views of my role in working with school-age children and to describe my different work tasks. The observation sessions will be conducted over a period of no longer than three weeks and the researcher will attempt to balance the number and length of observations across participants at a site. The purpose of the observations is to allow the researcher to develop her understanding of standard SLP workplace tasks and the role of organization and government policy in these tasks. The researcher will make written notes of her observations. I understand that the researcher will be conducting a cursory review of client files to observe how the paperwork within the files documents my work process and reflects organization and/or government policies. I understand that no information specific to individual students will be used in the research. The follow-up interview session will take no longer than one hour and will be used by the researcher to clarify information obtained in the initial interview and observations. All interviews will be audiotaped, as this is essential for accuracy. The tapes will be transcribed and the information will be analyzed in conjunction with information provided by other participants in phase two of the study.

Consent:

I, ____, agree to participate in the above named project.

I have read the information letter provided and I understand that my participation in this project is voluntary. I may refuse to answer any questions I choose, and I may withdraw from the study at any time without consequences. I recognize that I may not necessarily benefit from the study.

I also understand that all information given will be treated confidentially. My name will not be associated with any publications or presentations arising from the research. All information collected will be kept in a locked filing cabinet in the Centre for Research on Literacy at the University of Alberta. The information will be retained for a minimum of five years following completion of the research and will then be destroyed.

All questions that I had about the project have been answered to my satisfaction, but I will be free to ask further questions of the researcher at any time.

If I have any concerns or complaints, I may contact the student researcher, Heather Sample Gosse, at 780-416-1082 or Ms. Sample Gosse's supervisor, Dr. Linda Phillips, at 780-492-4250. I may also wish to contact Dianne Oberg, Chair of the Department of Elementary Education, at 780-492-4273.

The plan for this study has been reviewed for its adherence to ethical guidelines and approved by the Faculties of Education and Extension Research Ethics Board (EEREB) at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Chair of the EEREB at 780-492-3751.

______________________________	____________________
Participant's Signature	Date
______________________________	____________________
Signature of Witness	Date
______________________________	____________________
Student Researcher's Signature	Date
______________________________	____________________
Supervisor's Signature	Date

Stage One Informal Interview Information Letter

Date of Letter Release

Dear (participant),

I am writing to ask your consent to participate in my study on the provision of speech-language services to school-age children. The research is for my dissertation as a doctoral student in the Department of Elementary Education at the University of Alberta. The purpose of this study is to develop a detailed description of the work of front-line speech-language pathologists and to determine the influence of organization and government policies on front-line practice. In addition to completing my dissertation, I will also be using the information in presentations and publications.

Your participation in the study will include participating in an informal interview or conversation about your experiences with the provision of speech-language services to school-age children. The interview session will take no longer than 30 minutes and will be conducted at your convenience. I will record the content of the conversation in my notes. These notes will be analyzed in conjunction with information collected from other participants in the study including speech-language pathologists, health administrators, teacher and school administrators, provincial government employees, and other relevant individuals.

Your participation in the study will be voluntary and you are able to withdraw at any time. I will not conceal any information from the participants. All information gathered will be treated confidentially. The findings from the study will be included in my dissertation and disseminated in scholarly and professional journals, books, conferences, and workshops. In these documents and presentations you will not be identifiable. All original data will retained in a secure venue for a period of five years and then destroyed.

The plan for the study has been reviewed for its adherence to ethical guidelines and approved by the Faculties of Education and Extension Research Ethics Board (EEREB) at the University of Alberta. For questions regarding participant rights and ethical conduct regarding participant ethics and ethical conduct of research, contact the Chair of the EEREB at 780-492-3751.

Please complete the attached consent form to indicate whether or not you would be willing to participate in the any of the research activities planned and forward the form to me according to our agreed upon plan. I will contact you shortly after the signing of this form to arrange a mutually convenient time for the initial interview.

Questions or concerns regarding this study can be directed to me, Heather Sample Gosse (780-416-1082) or my supervisor, Dr. Linda Phillips (780-492-4250). You may also wish to contact the chair of the Department of Elementary Education, Dr. Dianne Oberg (780-492-4273). I look forward to working with you throughout the duration of the study.

Sincerely,

Heather Sample Gosse M.Sc. R.SLP
Doctoral Student
Department of Elementary Education

Stage One Informal Interview Consent Form

Title:	A Study of Speech-Language Pathology Services for School-Age Children in Alberta
Student Researcher:	Heather Sample Gosse R.SLP, Doctoral Student, Elementary Education. Phone: 416-1082
Supervisor:	Dr. Linda Phillips, Centre for Research on Literacy Phone: 492-4250
Purpose:	The purpose of this study is to develop a detailed description of the work of front-line speech-language pathologists and to determine the influence of organization and government policies on front-line practice. My participation in the study will involve participating in an informal interview or conversation about my experiences with the provision of speech-language services to school-age children. The interview session will take no longer than 30 minutes and will be conducted at my convenience. The researcher will record the content of the conversation in her written notes. These notes will be analyzed in conjunction with information provided by other participants in the study.

Consent:

I, ______________________________, agree to participate in the above named project.

I have read the information letter provided and I understand that my participation in this project is voluntary. I may refuse to answer any questions I choose, and I may withdraw from the study at any time without consequences. I recognize that I may not necessarily benefit from the study.

I also understand that all information given will be treated confidentially. My name will not be associated with any publications and presentations arising from the research. All information collected will be kept in a locked filing cabinet in the Centre for Research on Literacy at the University of Alberta. The information will be retained for a minimum of five years following completion of the research.

All questions that I had about the project have been answered to my satisfaction, but I will be free to ask further questions of the researcher at any time.

If I have any concerns or complaints, I may contact the student researcher, Heather Sample Gosse, at 780-416-1082 or Ms. Sample Gosse's supervisor, Dr. Linda Phillips, at 780-492-4250. I may also wish to contact Dianne Oberg, Chair of the Department of Elementary Education, at 780-492-4273.

The plan for the study has been reviewed for its adherence to ethical guidelines and approved by the Faculties of Education and Extension Research Ethics Board (EEREB) at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Chair of the EEREB at 780-492-3751.

______________________________	____________________
Participant's Signature	Date
______________________________	____________________
Signature of Witness	Date
______________________________	____________________
Student Researcher's Signature	Date
______________________________	____________________
Supervisor's Signature	Date

Stage Two Participant Information Letter

Date of Letter Release

Dear (participant),

I am writing to ask your consent to participate in my study on the provision of speech-language services to school-age children. The research is for my dissertation as a doctoral student in the Department of Elementary Education at the University of Alberta. The purpose of this study is to develop a detailed description of the work of front-line speech-language pathologists and to determine the influence of organization and government policies on front-line practice. In addition to completing my dissertation, I will also be using the information in presentations and publications.

Your participation in the study will involve participating in a formal interview about your experiences with the provision of speech-language services to school-age children. I will ask questions about the influence of organization and government policies on front-line SLP practice. The interview will take no longer than one hour and will be conducted in person whenever possible but a phone interview may be necessary in some cases. The interview will be audiotaped, as this is essential for accuracy. The tapes will be transcribed and the information will be analyzed in conjunction with information collected in stage one of the study. In stage one, I will be interviewing and observing front-line speech-language pathologists to develop a detailed description of their work and to gain initial understanding of the influence of organization and government policy on their work.

Your participation in the study will be voluntary and you are able to withdraw at any time. I will not conceal any information from the participants. All information gathered will be treated confidentially. The findings from the study will be included in my dissertation and disseminated in scholarly and professional journals, books, conferences, and workshops. In these documents and presentations you will not be identifiable. All original data will retained in a secure venue for a period of five years and then destroyed.

The plan for the study has been reviewed for its adherence to ethical guidelines and approved by the Faculties of Education and Extension Research Ethics Board (EEREB) at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Chair of the EEREB at 780-492-3751.

Please complete the attached consent form to indicate whether or not you would be willing to participate in the any of the research activities planned and forward the form to me according to our agreed upon plan. I will contact you shortly after the signing of this form to arrange a mutually convenient time for the initial interview.

Questions or concerns regarding this study can be directed to me, Heather Sample Gosse (780-416-1082) or my supervisor, Dr. Linda Phillips (780-492-4250). You may also wish to contact the chair of the Department of Elementary Education, Dr. Dianne Oberg (780-492-4273). I look forward to working with you throughout the duration of the study.

Sincerely,

Heather Sample Gosse M.Sc. R.SLP
Doctoral Student
Department of Elementary Education

Stage Two Participant Consent Form

Title: A Study of Speech-Language Pathology Services for School-Age Children in Alberta

Student Researcher: Heather Sample Gosse R.SLP, Doctoral Student, Elementary Education. Phone: 780-416-1082

Supervisor: Dr. Linda Phillips, Centre for Research on Literacy Phone: 780-492-4250

Purpose: The purpose of this study is to develop a detailed description of the work of front-line speech-language pathologists and to determine the influence of organization and government policies on front-line practice. My participation in the study will involve participating in a formal interview about my experiences with the provision of speech-language services to school-age children. The researcher will ask questions about the influence of organization and government policies on front-line practice. The interview will take no longer than one hour and will be conducted in person by the researcher whenever possible but a phone interview may be necessary in some cases. The interview will be conducted at my convenience and will be audiotaped, as this is essential for accuracy. The tapes will be transcribed and the information will be analyzed in conjunction with information provided by other participants in phase one of the study.

Consent:

I, ____, agree to participate in the above named project.

I have read the information letter provided and I understand that my participation in this project is voluntary. I may refuse to answer any questions I choose, and I may withdraw from the study at any time without consequences. I recognize that I may not necessarily benefit from the study.

I also understand that all information given will be treated confidentially. My name will not be associated with any publications and presentations arising from the research. All information collected will be kept in a locked filing cabinet in the Centre for Research on Literacy at the University of Alberta. The information will be retained for five years following completion of the research and will then be destroyed.

All questions that I had about the project have been answered to my satisfaction, but I will be free to ask further questions of the researcher at any time.

If I have any concerns or complaints, I may contact the student researcher, Heather Sample Gosse, at 780-416-1082 or Ms. Sample Gosse's supervisor, Dr. Linda Phillips, at 780-492-4250. I may also wish to contact Dianne Oberg, Chair of the Department of Elementary Education, at 780-492-4273.

The plan for the study has been reviewed for its adherence to ethical guidelines and approved by the Faculties of Education and Extension Research Ethics Board (EEREB) at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Chair of the EEREB at 780-492-3751.

Participant's Signature	Date
Signature of Witness	Date
Student Researcher's Signature	Date
Supervisor's Signature	Date

Appendix D: Interview Guides

This appendix contains four interview guides. I used the first to guide the initial interviews with participating front-line SLPs and the second to guide their final interviews. I used the third guide at the beginning of the informal interviews conducted in stage one. Finally, the fourth interview guide was used at the beginning of the stage two interviews.

Guide for Initial SLP Interviews

*Confirmatory questions are provided in brackets.

What professional training do you have? (Where were you trained? What is your highest degree in the profession?)

What work experience do you have as a speech-language pathologist? (How long have you worked with school-age children? How long have you worked in your current position?)

What do you feel is the ideal role for an SLP serving school-age children? (What do you see as the ideal role for SLPs within the educational system? Do you think an SLP should ideally have a presence within the classroom? If yes, to what degree? If no, why not? What degree of interaction do you think an SLP should ideally have with school staff? How relevant do you think the school curriculum is to ideal SLP practice with school-age children?)

Does your role as an SLP in the health region allow you to fulfill this ideal role for the school-age children you serve? If yes, why? If no, why not? How would you describe your role?

What is your typical work day like? (How long is your work day? How many hours are you required to work? Do you manage to get done when you need to do in order to serve your caseload the way that you would like to? Do you work additional hours beyond that which is required?) If working part-time – Why do you work part-time?

What service delivery model do you use? (What types of activities are you engaged in? How frequently does (each type of activity) occur? When does (each type of activity) occur? How do you measure your caseload?)

What are the issues that influence your ability to do your work? (Has a shortage of personnel influenced your ability to do your work? If so, how? Does your caseload size influence your ability to do your work? If so, how? Has a shift within the health region influenced your ability to do your work? If so, how? Does a lack of guidelines for service delivery to school-age children influence your ability to do your work? If so, how? Do you work with support personnel? If yes, tell me about your work with support personnel. If no, why not? Are you involved with telepractice? If yes, tell me about your work with telepractice? If no, why not? Do you conduct or use outcomes research? If yes, tell me about your work with outcomes research. If no, why not? Do you attempt to use evidence-based practice? Is yes, tell me about your involvement with evidence-based practice. If no, why not?)

Are you satisfied with your current work situation? If yes, why? If no, why not? What do you think could realistically be done to improve your current work situation? In an ideal world, what do you think could be done to improve your current work situation?

Guide for Final SLP Interviews

I'd would like to clarify some of the things I observed when I accompanied you to…the school, the meeting, etc. (Describe observations and initial interpretations.) Do I have the right picture?

Is there any other information that would be useful to me in understanding this situation? In our discussions and during my observations, I began to think that perhaps your actual role in (particular context or task) could be described as (describe initial interpretations).

Do you think that this is one accurate way of describing your role in (particular context or task)? If no, why not? If yes - I was also wondering if this interpretation of your actual role in (particular context or task) was in conflict with what you initially thought your role was in (particular context or task). What do you think? If yes, how do you feel about this apparent conflict?

Guide for Stage One Informal Interviews

I am trying to understand how speech-language services are provided in this area. I have come to realize that I need to understand more about (name particular situation). Please tell me what you know (about particular situation).

Guide for Stage Two Interviews

I have been working to understand the factors that influence how speech-language services are provided to school-age children within an Alberta health region. I have come to realize that I need to understand more about (name particular situation). Please tell me what you know (about particular situation).

Appendix E: Profile of Participating SLPs

Characteristic	Participants		ACSLPA Members	
	N	%	N	%
Professional Training Site				
Alberta	8	57	421	58
Out-of-Province	6	43	306	42
Highest Degree Earned				
Bachelor's	2	14	116	
Master's	12	86	771	
Years of Work Experience				
None	1	7		
Less than 5	2	14		
5-10	3	21		
More than 10	8	57		
Type of Work Experience				
All Populations	9			
Preschool and School	4			
School Only	1			
Total FTE Worked				
Less than 0.5	3	21		
Part-time (>0.5 but <1.0)	2	36	301	42
Full-time (1.0)	9	64	421	58

Characteristic	Participants		ACSLPA Members	
	N	%	N	%
Number of Schools Served				
1-2	3	21		
3-5	7	50		
More than 5	4	29		

Appendix F: Schools and Jurisdictions Served

Tables 1, 2, and 3 illustrate the FTEs of the SLPs serving school-age children from the U1, U2, and rural offices and the school jurisdictions and number of schools served. The school jurisdictions have been named according to whether they were public, Catholic, private Christian, or private special needs and the 8 public and 4 Catholic jurisdictions within the region have been given identifying numbers. School jurisdictions have been profiled in Table 4.

Table 1

U1 Schools and Jurisdictions Served

Total FTE	FTE for School-Age	Jurisdictions Served
Schools Only Practice		
1.0	1.0	1.0 Catholic 1 (5 schools)
1.0	1.0	0.6 Public 1 (3 schools), 0.4 Public 4 (3 schools)
0.7	0.7	0.4 Public 3 (3 schools) 0.3 Private Christian (2 schools)
Schools/Preschool Practice		
0.8	0.4	0.4 Public 1 (2 schools)
0.5	0.3	.15 Public 1 (2 schools), .15 Catholic 1 (3 schools)
1.0	0.8	0.2 Public 3 (1 school), 0.3 Public 4 (2 schools), 0.3 Public 5 (2 schools)
1.0	0.6	0.3 Catholic 1 (1 school), 0.25 Private Special Needs (1 school), 0.05 Private Christian (2 schools)
1.0	0.4	0.2 Public 4 (1 school), 0.2 Catholic 1 (1 school)

Table 2

U2 Schools and Jurisdictions Served

Total FTE	FTE for School-Age	Jurisdictions Served
Schools Only Practice		
0.4	0.4	0.4 Public 2 (2 schools)
1.0	0.8	0.8 Public 2 (6 schools)
Schools/Preschool Practice		
1.0	0.8	0.8 Public 2 (5 schools)
0.5	0.3	0.3 Public 2 (3 schools)

Table 3

Rural Schools and Jurisdictions Served

Total FTE	FTE for School-Age	Jurisdictions Served
Schools Only Practice		
1.0	1.0	0.7 Public 3 (4 schools), 0.2 Catholic 1 (1 school), 0.1 Private Christian (1 school)
1.0	1.0	0.8 Public 4 (5 schools), 0.2 Catholic 1 (1 school)
1.0	1.0	1.0 Public 3 (6 schools)
0.95	0.95	0.8 Public 4 (4 Schools), 0.15 Public 5 (2 schools)
0.8	0.8	0.4 Public 6 (2 schools), 0.4 Public 2 (2 schools)

Table 3 Continued

Rural Schools and Jurisdictions Served

Total FTE	FTE for School-Age	Jurisdictions Served
Schools Only Practice		
0.6	0.6	0.6 Public (5 schools)
0.4	0.4	0.2 Public 2 (1 school), 0.2 Catholic 2 (1 school)
0.3	0.3	0.3 Public 3 (2 schools)
Schools/Preschool/Team Practice		
1.0	0.8	0.6 Public 7 (5 schools), 0.2 Catholic 3 (2 schools)
1.0	0.5	0.5 Public 6 (2 schools)
1.0	0.5	0.25 Private Special Needs (1 school), 0.15 Public 4 (1 school), 0.1 Private Christian (2 schools)
1.0	0.5	0.275 Public 3 (2 schools), 0.1 Private Christian (1 school), 0.075 Catholic 2 (1 school)
1.0	0.5	0.4 Public 6 (2 schools), 0.1 Private Christian (1 school)
1.0	0.5	0.3 Public 3 (1 school), 0.1 Public 4 (1 school), 0.1 Private Christian (1 school)
0.6	0.4	0.3 Public 7 (3 schools), 0.1 Catholic 3 (1 school)
0.2	0.1	0.1 Private Christian (1 school)

Table 3 Continued

Rural Schools and Jursidictions Served

Total FTE	FTE for School-Age	Jurisdictions Served
Schools/Preschool/Sole Practice		
1.0	0.8	0.7 Public 4 (5 schools), 0.1 Catholic 1 (1 school)
1.0	0.5	0.25 Public 8 (3 schools), 0.25 Public 5 (2 schools)
1.0	0.5	0.25 Public 5 (2 schools), 0.05 Public 4 (1 school), 0.2 Catholic 4 (1 school)
0.4	0.2	0.2 Public 8 (3 schools)
0.3	0.1	0.1 Private Christian (1 school)

Table 4

Jurisdiction Profiles

Jurisdiction	# of Schools	SLP FTE	Total Student Population	Total Student Population/ SLP FTE	K-4 Student Population	K-4 Student Population/ SLP FTE
Public 1	34	3.1	9627	3105	3245	1047
Public 2	19	3.0	4397	1466	1533	511
Public 3	28	3.0	7682	2561	2576	859

Table 4 Continued

Jurisdiction Profiles

Jurisdiction	# of Schools	SLP FTE	Total Student Population	Total Student Population/ SLP FTE	K-4 Student Population	K-4 Student Population/ SLP FTE
Public 4*	24	3.55	7855	2213	3024	852
Public 5*	10	.95	2388	2514	912	960
Public 6	19	2.0	5292	2746	1982	991
Public 7*	8	.9	2347	2934	782	978
Public 8*	7	.45	1380	3067	486	1080
Catholic 1	23	2.1	5868	2794	2226	1060
Catholic 2	3	.475	1259	2650	565	1189
Catholic 3	1	.2	416	2080	193	965
Catholic 4	3	.3	206	687	106	353
Private Christian	15	1.1	3854	3504	1258	1144
Special Needs	2	.5	90	180	N/A	N/A

*Denotes jurisdictions only partly within health region

Appendix G: Review of Priority Classification Summary and Quota System

To further investigate how health region policies influenced front-line SLP practice, I reviewed the *Priority Classification Summary* and *Quota System* policies in detail.

Priority Classification Summary

The *Priority Classification Summary (PCS)* was designed to assist SLPs in determining an individual client's priority for treatment. Based on documents from the *Structural Process and Outcome Standards for Alberta Health Unit Speech-Language Pathology Programs* (Alberta Health, 1993), the PCS guided SLPs through four areas of consideration; severity, urgency, related factors (including impact, reaction, motivation, support, and concomitant condition), and prognosis with clients to receive a rank from 0 – 5 in each area with 5 being the highest priority. After ranking each area, SLPs were directed to sum the points received in each area and assign the client an overall priority status according to the following categories: 0-4 points = P4, 5-9 points = P3, 1-14 points = P2, 15-20 points = P1.

In discussions with front-line SLPs, they commented that the priority designations obtained using the PCS system were of limited utility in determining caseloads. Ratings were recognized as inconsistent among SLPs. For example, SLPs taking over established caseloads reported that they could not rely on the previous clinician's ratings to establish service delivery plans for the new school year. Many SLPs reported that the vast majority of clients were assigned a P2 ranking. Because not all of these clients could be seen in the time available, SLPs had to judge who to select for treatment. When asked how they made this additional judgment, most of the SLPs spoke of considering the parental support available to particular clients, with clients with more parental support being more likely to receive treatment. At first, I became concerned that front-line SLPs were placing clients in an unacknowledged "double jeopardy" situation because careful reading of the PCS would see "support" considered as part of the ranking in the related factors area. A client with low parental support, therefore, should have already been "penalized" for that lack of support in the PCS without experiencing additional discounting after the fact. Upon review of the Speech and Language Services Procedure Manual, however, it became clear that the front-line SLPs were not acting without regional guidance for their actions. Indeed, the *Treatment Caseload Selection* procedure specified a number of factors for additional consideration when selecting a caseload including "existing supports" which was specified as the SLP, assistant, or volunteer time available, and parental support. The procedures manual also contained a chart that further specified looking at "support" after prioritization was established – cases without support were to be placed on the treatment waiting list and reviewed in 6 months to 1 year with parents possibly referred to alternate services. No guidance was provided to SLPs in how to judge parental support and no rationale was provided for the significant weight put on parental support during the client selection process.

Another interesting situation arose when front-line SLPs commented that they were to balance their caseloads, seeing a relatively equal number of P1, P2, and P3-ranked clients. In fact, one SLP commented that they were not to spend all of their time serving the most severe cases because they would then be more prone to burn-out. This situation seemed immediately problematic to me as it did not seem logical to spend time identifying which clients were the highest priority for treatment and then equally select clients from all levels of priority. Once again, though, the front-line SLPs were receiving guidance from regional policies. Policy documents specified a consideration of the ratio of P1, P2, and P3-ranked clients in treatment noting that "an SLP caseload should not contain 100% P1 clients, nor should all P3 clients be placed on the treatment waiting list. A balance must be established so that some P3, P2, and P1 clients are seen." (Policy Number SLP-C21d) but not providing any rationale for this consideration.

As previously noted, the region's PCS was based on documents from the *Structural Process and Outcome Standards for Alberta Health Unit Speech-Language Pathology Programs* (Alberta Health, 1993). Additional documents from this resource were provided as an addendum to the region's procedures manual. Review of these documents and the original source suggested that the PCS was not being used by front-line SLPs as the original creators intended. The PCS was originally designed to provide an objective determination of a clinician's caseload but in practice, the objectivity had been lost due in part to front-line SLPs' incomplete understanding of the background of the document and in part to additional considerations added onto the process through regional policies. The most undefined and therefore most misused area within the PCS was "related factors". The ranking in the related factors area was intended to be an average of separate ranks for impact, reaction, motivation, degree of support, and effect of concomitant condition on communication, although front-line SLPs did not appear to formulate the ranking in that manner. While some of the additional considerations put forward in regional policies appeared to make good sense, such as time available from professional and support staff, room on caseload, length of time on treatment waiting list, whether clients who had received treatment would benefit from a continuation, and school input, no clear guidance was given to front-line SLPs about *when* and *how* they were to consider these additional considerations. For example, some of the considerations required an evaluation of a particular client's circumstances (i.e., length of time on treatment waiting list, previous treatment, school input), while others related more to managing the caseload as whole (i.e., professional and support staff time available, room on caseload). The latter factors appeared to be most appropriately considered prior to, not during, selection of individual cases but this was not specified in the policy.

Quota System

The main procedure used to manage caseloads in the region was the *quota system*. The system entailed the use of a single-page chart designed to assist front-line SLPs in determining the maximum number of clients they should see at each school in a specific month (caseload target). To complete the form, SLPs wrote in each of their schools and the FTE allocated to that school. To determine the target for direct service they would then multiply 40 (maximum # of clients recommended for service by a full-time SLP providing only direct service) by the FTE assigned to the school by the percentage of clients requiring direct service. For example, if SLP, "Joe", was assigned one day a week or .2 FTE to School A and 50% of the clients at School A required direct service, the maximum number of clients "Joe" should directly serve at School A in the month would be 4 (40 x .2 x .5). Using the quota system, front-line SLPs could also determine the target for consultation service by multiplying 70 (maximum number of clients recommended for service by a full-time SLP providing only consultation service) by the FTE assigned to the school by the percentage of clients requiring consultation service. For example, taking "Joe's" assignment of one day per week (.2 FTE) to School A and the remaining 50% of clients at School A requiring consultation service, the maximum number of clients "Joe" should provide consultation to at School A in the month would be 7 (70 x .2 x .5). Space was provided on the form for writing in the actual numbers of clients seen for direct and consultation service in the month. When the system was first instituted, front-line SLPs were required to submit the completed forms to management on a monthly basis. The manager indicated that this requirement had been instituted to encourage front-line SLPs to use the system and to help the manager monitor caseload sizes so that caseload management assistance could be provided to those SLP who were struggling to manage large caseloads. At the time of the study, submitting the quota system forms to management was optional.

The manager reported having designed the quota system as a response to issues arising to issues about large caseload sizes and low sense of efficacy reporting by front-line SLPs at group meetings. Both front-line SLPs and management noted that the introduction of the quota system had caused some concern in the schools due to an impression that fewer students were being seen each month. Whether this was actually the case was unclear. Front-line SLPs did not seem to have access to historical data about how many students had traditionally been seen each month in particular schools. Indeed, caseload demands at particular schools would normally fluctuate over time rendering such statistical information less relevant.

The quota system was appreciated by most front-line SLPs for providing them with support to keep their caseload manageable. They appeared to value the ability to "blame" caseload restrictions on a management policy, at least partially alleviating personal pressure to see more cases. As S2 commented, the quota system, "helped us make our caseloads more manageable and sort of gave us permission to tell the schools, 'Whoa, I'm full. These ones are going to have to sit on a waiting list.'" (S2 R-S-T Int 1 LN 378-380).

The quota system also served to encourage front-line SLPs to keep up with the paperwork requirements of seeing clients. Front-line SLPs noted that part of achieving the targets defined by the quota system was not working with additional clients until all the paperwork such as reports, treatment plans and chart notes had been completed for those originally targeted.

Front-line SLPs understood the full-time caseload maximums of 40 for direct service and 70 for consultation as coming from Canadian Association of Speech-Language Pathologists and Audiologists (CASLPA) guidelines but no documentation was provided to validate these guidelines. Also concerning was the fact that front-line SLPs reported different definitions of "direct" and "consultation" with some including work with SLP assistants under the direct service targets and others including it under consultation service targets. This confusion was understandable because SLP assistant work was typically considered direct service in Speech and Language Services procedures. For the purposes of the quota system, however, management's intention was that work with SLP assistants would be considered consultation.